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Health Care Financing

Status Report

Research and Demonstrations in Health Care Financing

January 1986 Edition

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Health Care Financing

Status Report

The Office of Research and Demonstrations (ORD), Health Care Financing Administration (HCFA), directs more than 300 research, evaluation, and demonstration projects. A central focus is on program expenditures as they relate to reimbursement, coverage, eligibility, and management alternatives under Medicare and Medicaid. Study activity also examines program impact on beneficiary health status, access to services, utilization, and out-of-pocket expenditures. The behavior and economics of health care providers and the overall health care industry are also topics of investigation.

These activities are carried out by three major components—the Office of Research, the Office of Demonstrations and Evaluations, and the Office of Operations Support. The Office of Research conducts and supports data collection efforts and research on health care providers, reimbursement, beneficiary behavior, and health care utilization. The Office of Demonstrations and Evaluations funds, manages, and evaluates pilot programs that test new ways of delivering and financing Medicare and Medicaid services. The Office of Operations Support provides ORD-wide administrative direction for its research, demonstration, and evaluation projects, which includes the budget and accounting operations; grants, cooperative agreements, and contracts-award process; and publications and information resources program.

This report provides basic information on active intramural and extramural projects in a brief format. These projects are used to assess new methods and approaches for providing quality health care while containing costs, and they often provide the basis for making critical policy decisions on health care financing issues.

Projects are arranged according to ORD budget priority areas and subject categories. The synopsis on each project includes the title, project number, project period, name and address of awardee, contractor, or grantee organization, Federal project officer with primary responsibility for the project, a brief description, and the status of the project as of September 30, 1985. When a project involves research and development funds, the total funding amount for the life of the project is included. Remaining extramural projects are being conducted with waivers that permit innovations to financing and delivery of health services under the Medicare and Medicaid programs.

This is the sixth edition of the *Status Report*. Updated editions will be produced on an annual basis. The information presented should be of use to policy officials, health planners, and researchers in examining the range of research and demonstration activities that are undertaken by ORD and the implications of results and findings.

Health Care Financing Status Report

Research and Demonstrations in Health Care Financing

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Office of Research and Demonstrations
Baltimore, Maryland
January 1986

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HOSPITAL PAYMENT

Inpatient General

Reducing Inappropriate Use of Inpatient Medical, Surgical, and Pediatric Services--Extension of the Appropriateness Evaluation Protocol

Project No.: 18-C-98317/1-02
Period: May 1983 - October 1985
Funding: $ 245,073
Award: Cooperative Agreement
Awardee: University Hospital, Inc.
75 East Newton Street
Boston, Mass. 02118
Project Officer: Sherry A. Terrell
Division of Reimbursement and Economic Studies

Description: The purpose of this cooperative agreement was to revise the Appropriateness Evaluation Protocol (AEP) to deal with two concerns: the problem of surgical admissions which should be performed on an outpatient basis, and the problem of indications for performance of surgical procedures. The awardee also conducted a formal experimental trial of the effectiveness of educational feedback of AEP results to hospital administrators and physicians on lowering levels of inappropriateness.

Status: Criteria development for inpatient and outpatient surgical location and timing has been completed. In addition, validity and reliability trials were completed. Data collection in eight Massachusetts hospitals was begun and continued through late August. Feedback is being provided to administrative and medical staffs on a physician-specific basis at participating hospitals. A final report is expected in Spring 1986.

An Independent Evaluation of the Reliability of the Standardized Medreview Instrument

Project No.:	HCFA-84-1099
Period:	July 1984 - June 1985
Funding:	$ 9,500
Award:	Contract
Contractor:	Warren S. Blumenfeld Georgia State University College of Business Administration University Plaza, S.E. Atlanta, Ga. 30303
Project Officer:	Sherry A. Terrell Division of Reimbursement and Economic Studies

Description: The purpose of this project was to critically evaluate the reliability of the Standardized Medreview Instrument (SMI), a medical utilization review methodology. The instrument was assessed using the Standards for Educational and Psychological Testing of the American Psychological Association (APA) as a guideline to examine the psychometric properties of the instrument.

Status: Using APA guidelines, the analysis indicated that the construct and content validity are satisfactory. In addition, interrater reliability and instrument reliability were examined. The reviewer found that primary strengths of the SMI were the relevance and the quality of the report and instrument freedom from bias. Instrument reliability was not reported by the SMI developers and was thought to be a possible source of potential weakness. That interrater reliability was addressed by an interdisciplinary team was considered a strength. Finally, the training package was found to be a positive aspect of the SMI project. A final report was received June 1985.

Appropriateness of Hospitalization: A Comparative Analysis of Reliability and Validity of the Appropriateness Evaluation Protocol and the Standardized Medreview Instrument

Project No.: 18-C-98582/5-01
Period: July 1984 - April 1986
Funding: $ 353,280
Award: Cooperative Agreement
Awardee: Michigan Health Care Education and Research Foundation, Inc.
600 Lafayette East
Detroit, Mich. 48226
Project Officer: James Beebe
Division of Beneficiary Studies

Description: The purpose of this research is to assess the relative reliability and validity of the Appropriateness Evaluation Protocol (AEP) and the Standardized Medreview Instrument (SMI) in identifying the appropriateness of medical, surgical, and gynecological admissions and days of stay in acute-care hospitals. The AEP was developed by Boston University and the SMI by Systemetrics, both under Health Care Financing Administration funding. A second focus is to estimate Detroit area rates of inappropriate care and how these rates are related to hospital characteristics and patient characteristics.

Status: The instruments have been applied to about 1,200 admissions to hospitals in the Detroit area. Results are being analyzed. A final report is expected in April 1986.

Longitudinal Studies of Local Area Hospital Use

Project No.: 18-C-98512/5-01
Period: July 1984 - July 1987
Funding: $ 214,290
Award: Cooperative Agreement
Awardee: University of Michigan
3014 Administrative Building
Ann Arbor, Mich. 48109
Project Officer: Kenneth Haber
Division of Reimbursement and Economic Studies

Description: This project will pursue longitudinal studies of local area hospital use in Michigan, tracing the 1980-82 recession, revisions to Medicare, the development of capitation and other incentive systems, and other factors affecting hospital use. Beginning in 1978, under previous Health Care Financing Administration funding, acute hospital use for 60 market-defined service areas in Michigan's lower peninsula (10 million persons) was identified and studied. Beginning in 1980, comprehensive hospitalization data have been collected annually on this population and will continue indefinitely. The data source available (Michigan inpatient data base) includes all use and can be subdivided by age and expected source of payment. Previous studies of these subgroups have indicated strong associations across groups. Analyses of the data will include:

- Changes in Medicare discharge rates, before and after adjustments for population and provider characteristics.
- Changes in the access characteristics associated with changes in the Medicare rates and population characteristics.
- Changes in the community-wide, Medicare, and non-Medicare discharge rates associated with growth of capitation and preferred provider organization payment.

This project was funded because continued study of Michigan will add to the conceptual understanding of hospital use, yielding theories testable elsewhere. No opportunity for a longitudinal study of a mixed rural and urban population of several million has existed before. This research will examine the stability of market areas, trends in hospital use measures, and the relationships to external socioeconomic factors. Findings could suggest several improvements in public and private policies to control hospital care costs.

Status: Data for 1981, 1982, and 1983 have been reformatted from individual patient records to community-based statistical files. Reports describing hospital use in Michigan by year and community with comparisons to the preceding year have been produced for 1980, 1981, and 1982. Future research will include an evaluation of disease staging as a case-mix indicator, an analysis of factors associated with variations in use, and the implications of implementation of Medicare's prospective payment system. A final report is expected in July 1987.

Disproportionate Share Hospitals: Costs and Case Mix

Funding: Intramural
Project Directors: J. Michael Fitzmaurice and Kenneth Haber
Division of Reimbursement and Economic Studies

Description: Hospitals that serve a significantly disproportionate share of low-income patients are frequently called disproportionate share hospitals (DSH's). Those hospitals are often the health care "providers of last resort" for patients who cannot afford to pay for their hospital care and are not covered under Medicaid. Because of this special role, disproportionate share hospitals frequently incur costs for services provided to many of their (poor) patients for which they do not receive direct reimbursement. Tax-financed subsidies often come from the State or local governments that have jurisdiction over these hospitals, but the hospitals' patient care costs may not be fully covered by these subsidies. This leads to DSH's expenses being greater than revenues and to reduced access to hospital care for part of the population. In the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress directed the Secretary, Department of Health and Human Services, to consider the "special needs" of hospitals "that serve a significantly disproportionate number of patients who have low income or are entitled to benefits" under Medicare in the application of the Section 101 total operating expense-per-case limits. In addition to TEFRA, there is also concern about the level of rates that DSH's would face under the Medicare prospective payment system. As part of considering the "special needs" of DSH's, this study will examine the Medicare cost reports of public general hospitals to determine if their costs are higher than the costs of other hospitals with the same characteristics.

Status: The data base for this study will be the 1984 Health Care Financing Administration's (HCFA) hospital Medicare cost report, cost-per-case file, the 1984 American Hospital Association Annual Survey, the HCFA master beneficiary file, and the 1984 Medicare patients' bills file from the Medicare provider analysis and review file. The files will be linked, edited, and expanded to include hospital cost and case-mix data. This study is expected to be completed in Fall 1986.

Analysis of Medicare Routine Costs Under Alternative Assumptions

Funding: Intramural
Project Director: J. Michael Fitzmaurice
Division of Reimbursement and Economic Studies

Description: This project grew out of a request from the Bureau of Eligibility, Reimbursement, and Coverage, Health Care Financing Administration, to examine the level of Medicare routine costs per day under alternative assumptions about the counting of labor (and false labor) room days as routine costs days. Additionally, the influence of obstetrical room days and pediatric routine days on the level of routine costs is to be investigated.

Status: Published data from the Commission on Professional and Hospital Activities, Hospital Administrative Services, and the American Hospital Association, and information derived from hospital Medicare cost reports is being used in this study. The possibility that excluding labor room days from the calculation of routine costs per day will increase the level of routine costs per day for hospitals is being investigated. Also investigated will be the possibility that excluding the costs of obstetrical room days and pediatric routine days from the costs of all other general service routine patient days (they are currently averaged together) will reduce routine costs per day. This analysis continues to be timely and is being extended beyond the analysis of 1981 hospital data.

Outpatient

Development of an Ambulatory Patient Classification System

Project No.:	18-C-98361/1-02
Period:	September 1983 - December 1985
Funding:	$ 713,404
Award:	Cooperative Agreement
Awardee:	Yale School of Organization and Management Box 1A New Haven, Conn. 06520
Project Officer:	John T. Petrie Division of Reimbursement and Economic Studies

Description: This study is developing and refining Yale's ambulatory patient classification system, ambulatory visit groups (AVG's). The AVG's, like diagnosis-related groups (DRG's), define a manageable number of categories of patients that have similar patterns of resource use. The AVG's take into account many resources used to deliver ambulatory care. The researchers are using the patient visit as the unit of analysis. They are employing a panel of physicians to review the grouping of patients suggested by statistical methods. The AVG's are defined using variables such as age, sex, principal diagnosis, and visit status (followup or new problem).

Status: This project has been extended to December 31, 1985. The Yale researchers have continued to revise the AVG's by basing the classification system on diagnoses. Their process of classifying ambulatory patients is three-tiered in nature. First, to facilitate the analysis and to insure medical interpretability, the Yale researchers subdivided data from the 1979 National Ambulatory Medical Care Survey (NAMCS) into major diagnostic categories. The 23 major diagnostic categories, which are based mainly on human organ systems, were also used as the initial grouping of diagnoses for the DRG's. Second, using codes from the International Classification of Diseases, 9th Revision, Clinical Modification, Yale subdivided the major diagnostic categories into 99 diagnosis "clusters." Another key factor in establishing the clusters was whether the patient was new or old (established). The physician panel helped determine these clusters and suggested changes and improvements. Third, Yale used statistical criteria to subdivide the 99 diagnosis clusters further into the AVG's. They used such variables as age, sex, patient's reason for seeing the physician, treatment, principal and other diagnoses, status of visit, and provider time. More than 200 AVG's have been identified.

Case Mix and Resource Use in Hospital Emergency Room Settings

Project No.:	18-C-98310/9-02
Period:	March 1983 - September 1985
Funding:	$ 595,227
Award:	Cooperative Agreement
Awardee:	University of California School of Public Health 405 Hilgard Avenue Los Angeles, Calif. 90024
Project Officer:	John T. Petrie Division of Reimbursement and Economic Studies

Description: The purpose of this study is to develop a patient classification scheme and case-based, cost-control system for hospital emergency room settings. Such a system might provide the Health Care Financing Administration with the foundation for reimbursing hospitals on a case-mix basis for the treatment of emergency room patients. The project will yield a system for integrating clinical and fiscal information, on a visit-specific basis, for hospital emergency rooms.

Status: The investigators have finished collecting, editing, and analyzing data for a sample of patients in four Los Angeles area hospitals (one teaching hospital and three nonteaching hospitals). They collected three types of patient-specific data for this study: provider time, medical records, and billing data. After merging the data bases, a cost-finding process was conducted to derive direct costs for various ancillary cost centers. They also derived total direct physician costs and nonphysician direct care costs. They constructed major diagnostic categories (MDC's) on the basis of principal diagnosis and have developed preliminary classifications for all of the MDC's. A final report detailing the final "emergency room groups" is expected in early 1986.

Development of a Case-Mix-Based Reimbursement Method for Hospital Outpatient Departments and Freestanding Clinics

Project No.: 18-P-98300/1-02
Period: March 1983 - March 1986
Funding: $ 790,108
Award: Grant
Grantee: Brandeis University
Florence Heller Graduate School
Waltham, Mass. 02139
Project Officer: John T. Petrie
Division of Reimbursement and Economic Studies

Description: The purpose of this grant is to provide accurate case-mix and patient socioeconomic data about visits to hospital outpatient departments (OPD's) and freestanding clinics. The grantee will develop a case-mix-based methodology, similar to the diagnosis-related groups (DRG's), which the Health Care Financing Administration can use for reimbursing hospital OPD's. The project is designed to provide policymakers with information on the special situation of hospital OPD reimbursement, and investigate why the same visit to a hospital OPD can cost twice as much as a visit to a physician in private practice. The case-mix reimbursement system will be used to compare OPD's with each other with respect to medical and social differences in case load, and to reimburse OPD's the same amount for patients of the same type. The grantee is examining whether a visit, an episode of illness, or a fixed period of time would be the most appropriate unit for a prospective payment system for outpatient care. In addition, Brandeis is collaborating with the Yale School of Organization and Management in the reformulation of the ambulatory visits groups (AVG's) classification system.

Status: Using the current AVG software, Brandeis has classified the data they collected in the first year from primary care, pediatric, and obstetrics-gynecology neighborhood health centers in Boston. They compared the most common AVG's for these clinics with internists in private practice. They examined resource use for the top 10 AVG's for adult primary care clinics and hospital outpatient departments, comparing total resource use for patients with and without social problems. Brandeis has also collected and analyzed data on hospital outpatient visits for cancer. The researchers have obtained data on more than 600 visits from a large Boston teaching hospital's hematology-oncology clinic. They have coded the questionnaires and have begun to collect data in the same hospital's adult radiation therapy clinic. They obtained actual charges for each visit, because, unlike primary care visits, oncology visits are technology intensive. Provider time is a relatively minor part of the overall resources used. Brandeis has continued to collaborate with Yale's ambulatory care project to categorize hospital outpatient department data using the original AVG software. They are also attempting to develop their own AVG's for outpatient-based oncology and hematology visits, which appear to be more costly than are similar visits to physicians in private practice.

Incorporating the Cost of Ambulatory Care into Case-Mix-Based Hospital Reimbursement

Project No.:	18-C-98426/3-02
Period:	September 1983 - September 1985
Funding:	$ 210,000
Award:	Cooperative Agreement
Grantee:	Blue Cross of Western Pennsylvania One Smithfield Street Pittsburgh, Pa. 15222
Project Officer:	John T. Petrie Division of Reimbursement and Economic Studies

Description: This project is developing a method of integrating hospital inpatient and outpatient reimbursement mechanisms, thereby eliminating the current reimbursement focus on location of services. The researchers are building on work performed under a previous Health Care Financing Administration's grant, in which the grantee developed an inpatient classification system called patient management categories (PMC's). The approximately 800 PMC's defined the diverse hospital resources required to manage clinically distinct patient types. The clinical definitions of PMC's are based on the reason for the hospital admission and combinations of discharge diagnoses. The project will yield a computerized outpatient data base, and assign hospital costs to each outpatient service to derive cost-based weights on the same relative scale as the inpatient PMC's. The project will identify patients who can be managed effectively in ambulatory settings but who are currently hospitalized. Finally, the project will analyze hospital inpatient and outpatient data to form a measure of the costliness of a hospital's overall patient mix. Each of the different ambulatory services and procedures will be considered as separate components of a visit and, therefore, each service or procedure will have a specific component cost.

Status: Blue Cross of Western Pennsylvania purchased data on ambulatory surgery programs from seven area hospitals. Using these data and reviewing documentation on ambulatory medicine and surgery, the researchers identified a list of ambulatory procedures. A panel of physicians reviewed this list to confirm that the procedures can be managed in ambulatory settings. The physicians ensured that the process of identifying these procedures met acceptable medical criteria, such as selecting those procedures with a low risk of postoperative complications or of a relatively short duration. The researchers have reviewed all PMC's as candidates for ambulatory management and have identified a total of 111 PMC's as recommended candidates for ambulatory management. They recommended these PMC's for one or more reasons: changing medical practice, application of the medical guidelines for ambulatory care, opinions of authoritative medical sources, and first-hand experiences of a nurse research assistant. The final report is expected in January 1986.

New York State Ambulatory Care Reimbursement Project

Project No.: 11-C-98574/2-01
Period: September 1984 - August 1987
Award: Cooperative Agreement
Awardee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: The New York State Department of Social Services and the Office of Health Systems Management jointly submitted this proposal. The awardee will develop and implement a prospective ambulatory care reimbursement methodology for both freestanding clinics and hospital-based ambulatory care services that is predicated on a uniform cost comparison by a patient-care service classification. The methodology will include adjustments to costs directly dependent on case mix and will also employ norms to ensure efficient production of services. New York feels that the result of this 3-year demonstration will be a greater understanding of the fundamental elements of ambulatory care costs, and, more importantly, the use of an equitable reimbursement policy for pricing ambulatory care in a manner that will promote economical delivery of health care and prudent cost growth.

Status: Most of the project's activity during the first year was concentrated on the development of data collection procedures and survey instruments necessary to measure variables that would be used in formulating case-mix measures. Data collection was completed, and analysis of the data is under way. The grantee is scheduled to implement the new reimbursement method in two demonstration areas in July 1986.

Hospital Prospective Payment

National Hospital Rate-Setting Study

Project No.:	500-78-0036
Period:	August 1978 - March 1986
Funding:	$ 6,293,070
Award:	Contract
Contractor:	Abt Associates, Inc. 55 Wheeler Street Cambridge, Mass. 02138
Project Officer:	Jeff McCombs Division of Hospital Experimentation

Description: This is the evaluation of the impact of 15 hospital prospective reimbursement programs from 1970 to 1979. The study focuses on the following eight areas:

- Hospital revenue, expenditures, and financial viability.
- Volume of hospital services.
- Hospital payroll costs and staffing.
- Patient care.
- Hospital capital formation, competition, and industrial structure.
- Hospital organization and administrative behavior.
- Access to hospital services.
- Medicare hospital and nonhospital costs.

In addition, the contract was modified to provide updates on program impacts in more recent years in the areas of volume of services and payroll and staffing (up to 1981), and patient care and revenue and expenditures (up to 1983).

Status: Final reports covering three of the above eight areas are currently available. These reports are available through the National Technical Information Service:

- "The Impact of State Hospital Prospective Reimbursement Programs on Medicare Hospital and Nonhospital Costs," accession number PB84-181544.
- "The Impact of State Hospital Prospective Reimbursement Programs on Hospital Capital Formation, Competition, and Industrial Structure: An Evaluation," accession number PB84-181445.
- "The Impact of Prospective Reimbursement on Hospital Payroll Costs and Staffing," accession number PB84-181403.

Final reports covering the remaining areas will become available in 1986.

Incentive Prospective Payment System for Hospitals Through Fiscal Intermediaries (Massachusetts)

Project No.:	95-P-98199/1-01
Period:	September 1982 - September 1986
Award:	Grant
Grantee:	Massachusetts Hospital Association 5 New England Executive Park Burlington, Mass. 01803
Project Officer:	Diane Rogler Division of Hospital Experimentation

Description: This statewide, all-payer, prospective hospital reimbursement project is being conducted by the Massachusetts Hospital Association for Medicare and by the Massachusetts Department of Public Welfare for Medicaid. The payment methodology was based on a contract (HA-29) which was between the hospitals and Blue Cross of Massachusetts. Hospital payments, including both inpatient and outpatient, are based on the "maximum allowable cost" (MAC) methodology which uses the actual fiscal year 1981 base-year costs, adjusted annually for inflation, volume changes, and certain exceptions. Each year, the amount paid to hospitals by Medicare and Medicaid is reduced by a 2-percent productivity factor. The payment system is administered by Blue Cross of Massachusetts. The Massachusetts Rate-Setting Commission approves each hospital's gross patient-service revenue based on its review of the Blue Cross MAC cost report and provides an oversight function. The rate of increase in Medicare hospital expenditures in Massachusetts is capped at the average rate of increase experienced by Medicare nationwide. If total Medicare hospital costs are less than 1.5 percent below the national average rate of increase, the hospitals will share in half of the savings.

Status: For the last year of the demonstration, Medicare agreed to most of the fiscal year 1985 changes to the new contract between Blue Cross and the hospitals (referred to as HA-30). HA-30 adopted the use of a case-mix method of pricing changes in inpatient volume and limited the criteria under which hospitals could seek an exception to the allowable cost base. For 99 of the 108 hospitals, the demonstration ended on September 30, 1985. As of October 1, 1985, Medicare inpatient payments to these hospitals will be based on the nationwide prospective payment system. The State is developing a payment system which will "wrap around" the Medicare payments and continue a statewide cost control program for the other payers. For the nine hospitals that have a July-June fiscal year, the demonstration will end on June 30, 1986. Based on the most current Medicare expenditure data available, it appears that the Medicare payments to Massachusetts hospitals have exceeded the maximum liability cap relative to the first year of the demonstration.

Rochester Area Hospitals' Corporation

Project No.:	95-P-97501/2-02
Period:	January 1980 - December 1986
Award:	Grant
Grantees:	State of New York/Rochester Area Hospitals' Corporation Empire State Plaza Tower Building Albany, N.Y. 12237
Project Officer:	Vic McVicker Division of Hospital Experimentation

Description: The Rochester Area Hospitals' Corporation Hospital Experimental Payment Program is a test of whether an areawide budget system will be effective in controlling hospital costs in a metropolitan area, and whether local decisionmaking can effectively allocate financial resources between hospitals to cover the cost of new services. This 7-year project, which includes all third-party payers (Medicare, Medicaid, and Blue Cross), was initiated January 1, 1980, and includes nine hospitals in the Rochester area of New York. The Hospital Experimental Payment Program places an upper limit or cap on the total revenue paid to the community's hospitals for all patient care. Each participating hospital's revenue for years is guaranteed at a base level, calculated primarily from the hospital's 1978 costs, trended forward to reflect inflation.

Status: Based on an assessment of the 5 years of operation, HCFA has agreed to extend the current demonstration through December 31, 1986, with an option for another year. Total Medicare payments under the demonstration (1980-84) increased at an average annual rate of 10.9 percent. This is substantially below the national average Medicare rate of 16.7 percent. Additionally, Medicare payments under the project are estimated to be lower in 1985 than under the national prospective payment system. The extension will incorporate the following objectives:

- The inclusion of capital costs under the community revenue cap.
- The use of replacement cost-accounting procedures for major movable equipment.
- New methods for spreading of community costs, such as charity care and direct medical education.
- The use of case-mix adjusters for measuring changes in inpatient volume.

Finger Lakes Area Hospitals' Corporation

Project No.: 95-P-97877/2-01
Period: January 1981 - December 1985
Award: Grant
Grantee: Finger Lakes Area Hospitals' Corporation
One Franklin Square
Geneva, N.Y. 14456
Project Officer: Vic McVicker
Division of Hospital Experimentation

Description: The Finger Lakes Area Hospitals' Corporation (FLAHC) is a test of whether an areawide budget system will be effective in controlling hospital costs in a rural area, and whether local decisionmaking can effectively allocate financial resources between hospitals to cover the cost of new services. This 5-year project, which includes all third-party payers (Medicare, Medicaid, and Blue Cross), was initiated January 1981, and includes eight hospitals in the rural Finger Lakes area of New York. The FLAHC payment program places an upper limit or cap on the total revenue paid to the community's hospitals for all patient care. Each participating hospital's revenue for 5 years is guaranteed at a base level, calculated primarily from the hospital's 1979 costs, trended forward to reflect inflation. In addition, a 2-percent contingency fund is administered by FLAHC to pay for increased hospital services and new and improved medical technology, and to provide working capital for participating hospitals.

Status: Based on an assessment of the first 3 years of operation, the hospitals and payers agreed to maintain the system for the entire 5-year test. Changes in utilization and cost levels of the FLAHC hospitals during the first year of the project were compared with the corresponding changes for two sets of comparable hospitals, one group located in the Syracuse area and the other in Northeastern New York State. From 1980 to 1981, the inpatient cost per day rose 13.3 percent in FLAHC, compared with 13.5 percent for the Syracuse peer group, and 15.0 percent for the Northeastern peer group. Patient discharges dropped 6.1 percent in the FLAHC area, compared with drops of 1.9 percent for the Syracuse peer group and 1.1 percent for the Northeastern peer group. The most relevant cost measure--total inpatient cost--rose 11.4 percent in FLAHC, compared with 16.6 percent for the Syracuse peer group and 14.5 percent for the Northeastern peer group. Other measures of inpatient utilization and cost performance also showed a beneficial effect. From 1980 to 1982, total Medicare payments in the FLAHC program increased by 31.7 percent (22.4 percent occurred in the first year), compared with an increase of 40 percent nationwide. For the last 2 years, reimbursement will be limited to trend plus 2 percent; the payers' cost savings should be increased during this period. The demonstration is scheduled to end December 31, 1985.

Prospective Reimbursement System Based on Patient Case Mix for New Jersey Hospitals

Project No.:	600-77-0022
Period:	December 1976 - December 1984
Funding:	$ 4,912,802
Award:	Contract
Contractor:	New Jersey State Department of Health CN 360 Trenton, N.J. 08625
Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: The purpose of this demonstration is to test a hospital prospective payment system based on diagnosis-related groups (DRG's). The award of a contract in 1976 to develop the payment methodology was followed by a 4-year Medicare and Medicaid waiver, effective January 1, 1980. The waiver approval included a cap which limits Medicare and Medicaid financial liability under the State program. All general acute-care hospitals were phased into the system over a 3-year period starting in 1980. The system is applicable to all patients and all third-party payers. Although the 467 DRG's used in the New Jersey system are identical to those employed in the Medicare prospective payment system, the New Jersey system differs significantly from the national program. In New Jersey, the rate calculation methodology is governed by State legislation and regulations. Additional financial elements such as bad debts and charity care are included; outliers account for almost 40 percent of the hospital inpatient revenue; and outpatient rates as well as inpatient rates are established by the New Jersey Department of Health.

Status: Because the regulations for Section 1886(c) of the Social Security Amendments of 1983 had not been published, the Medicare and Medicaid waivers were extended for an additional year to December 31, 1984. Section 1886(c) provides for the continuation of State hospital payment programs. In the interim, the State formally requested 1886(c) waivers according to draft guidelines. An 1886(c) waiver for inpatient services for the period January 1, 1985, to December 31, 1987, was approved in December 1984. Following an additional extension of the outpatient demonstration waiver, the 1886(c) waiver for outpatient services became effective on August 9, 1985.

Proposal for the Development of a Hospital Reimbursement Methodology for New York State for the 1980's

Project No.: 95-P-98216/2-01
Period: January 1983 - December 1985
Award: Grant
Grantee: State of New York Department of Health
Empire State Plaza
Tower Building, Room 1043
Albany, N.Y. 12237
Project Officer: Joe Cramer
Division of Hospital Experimentation

Description: This 3-year project is a test of a non-diagnosis-related group (DRG) prospective per diem payment system for all payers in the State. Rates are determined using 1981 costs as the base. Base-year allowable costs are calculated through the use of peer-group comparisons, with ceilings on ancillary costs and a combined routine cost/length-of-stay ceiling. Once allowable costs were determined, rates for 1983 were calculated by inflating the costs by a trend factor. In 1984 and 1985, a "rate-to-rate" methodology was applied. The system provides for the establishment of bad debt and charity-care pools on a regional basis to be supported by the payers.

Status: Several tasks necessary to implement New York's prospective hospital reimbursement methodology (NYPHRM) were completed. New York completed an initial assessment of compliance with the NYPHRM charge control provision and those facilities substantially out of compliance were notified by the Commissioner and told to realign their 1985 charges. Facilities were requested to submit a report containing an opinion by an independent certified public accountant as to whether the facilities met the criteria for distribution from bad debt and charity care pools. Based on financial data submitted by hospitals, the Office of Health Systems Management adjusted the 1985 rates of payment for the additional discretionary allowances. Pool administrators were advised of amounts to be distributed from 1984 regional transitional pools. Amendments to Part 86 clarified the appeals process, deleted the requirement that facilities fund separately depreciation for fixed and moveable equipment, and allowed distributions from 1985 financially distressed hospital pools to be based on aggregate bad debt and charity care losses for the period 1983-85. Rate adjustments for volume and trend factor changes were done in July. The Governor signed into law, in August 1985, a bill that would continue a cost-based system for Medicaid and Blue Cross in 1986. The Medicare program in New York reverts to the national DRG prospective payment system in 1986.

Prospective Payment System for Acute and Chronic Care Hospitals in Maryland

Project No.: 500-80-0044
Period: June 1980 - June 1985
Funding: $ 2,037,563
Award: Contract
Contractor: State of Maryland Health Services Cost Review Commission
201 West Preston Street
Baltimore, Md. 21201
Project Officer: Thomas A. Noplock
Division of Hospital Experimentation

Description: This project is testing the long-term effects of an all-payer, statewide hospital prospective payment system in Maryland. The Maryland Project uses a public utility commission's approach to hospital rate regulation. The Maryland Health Services Cost Review Commission (HSCRC) established hospital rates and then adjusted them for such items as inflation, volume changes, and pass-through costs. Currently, Maryland employs three separate systems: a detailed budget review system for individual hospitals; an automatic annual inflation adjustment for individual hospitals without a total budget review; and a payment system based on diagnosis, the Guaranteed Inpatient Revenue System.

Status: This project terminated as a demonstration project on July 1, 1985, but it is being continued as a program waiver under the authority of Section 1814(b) of the Social Security Act. A final report has been received.

Diagnosis-Related Groups and Nursing Resources

Project No.: 15-C-98500/1-01
Period: July 1984 - July 1986
Funding: $ 427,910
Award: Cooperative Agreement
Awardee: Yale University
School of Organization and Management
320 York Street
New Haven, Conn. 06520
Project Officer: Patricia Willis
Division of Reimbursement and Economic Studies

Description: This congressionally mandated study (Public Law 98-21) investigates the development of a diagnosis-related group (DRG)-specific nursing intensity measure for application in the management, planning, and budgeting of hospital nursing resources. This measure will be related to commonly used nurse staffing algorithms. It will be compatible with hospital cost-accounting systems so that it may be used to refine the contribution of nursing costs to the total costs of patient care. Also, it is intended that it should be empirically derived for each DRG, be clinically meaningful to nurses, and it should possess known statistical characteristics at the DRG level. Among the hospital nursing measures, the developers propose to examine the Grace-Reynolds Application and Study of Peto (GRASP) nursing intensity measure for five Massachusetts Health Data Consortium hospitals and billed nursing costs (i.e., charges) at St. Luke's Hospital in Phoenix, Arizona. These data will be analyzed by DRG to develop statistics for the GRASP points and charges, "cost" the nursing service for each DRG at each site, and analyze the intragroup variance within DRG's. Finally, the researchers will assess the extent to which nursing resource measures capture differences in patient severity within DRG's.

Status: The research team has acquired the proposed data bases and conducted preliminary analyses of this data. The final results of this study will be available late Summer 1986. They are expected to contribute significantly to the Office of Research and Demonstrations research agenda on severity of illness and other modifications to the DRG system.

Selected Analyses of the Prospective Payment System's Impact on Hospitals' Behavior

Project No.:	18-C-98606/3-02
Period:	July 1984 - January 1987
Funding:	$ 480,423
Award:	Cooperative Agreement
Awardee:	The Urban Institute 2100 M Street, NW. Washington, D.C. 20037
Project Officer:	Stuart Guterman Division of Reimbursement and Economic Studies

Description: This project is congressionally mandated under the Social Security Amendments of 1983 (Public Law 98-21). It will analyze the impact of the Medicare hospital prospective payment system (PPS) on three types of hospital behavior: the provision of services to Medicare beneficiaries by hospital outpatient departments; the discharge of Medicare beneficiaries to and provision of long-term care and home health services; and changes in hospitals' corporate structure and internal organization. The analysis is to be based primarily on data from a series of hospital surveys conducted by the Urban Institute (UI) and the American Hospital Association (AHA). Data on hospital revenue and expenses in 1980 and 1982 will be used to project expected hospital performance in a pre-PPS environment, and compared with data on actual hospital performance in 1984 and 1985.

Status: The 1984 fiscal year survey of hospitals was mailed in July 1985, with final data expected in January 1986. Analysis of data from the 1980 and 1982 surveys and some preliminary data from the 1984 survey began in Fall 1985.

Severity of Illness and Diagnosis-Related Groups in Selected Cancers

Project No.: 15-C-98678/4-01
Period: January 1985 - December 1987
Funding: $ 214,010
Award: Cooperative Agreement
Awardee: University of Miami
School of Medicine
Comprehensive Cancer Center for the State of Florida
P.O. Box 016960, D8-4
Miami, Fla. 33101
Project Officer: John C. Langenbrunner
Division of Reimbursement and Economic Studies

Description: This project utilizes existing data bases to evaluate the relationship between the intensity of disease and the cost of treating the disease for five common types of cancer—colon and rectum, lung, breast, cervix, and prostate. These five types of cancer represent more than 50 percent of new cancer cases. The project will utilize a staging algorithm developed by the American Joint Committee on Cancer as an adjunct to the current diagnosis-related group (DRG) system for the five types of cancer. New diagnosis categories will be developed that may explain a significantly greater proportion of the variation in resource consumption for treating the given types of cancer than the current DRG system.

Status: This study was awarded because of the Health Care Financing Administration's interest in DRG refinement issues, as well as its interest in policy development regarding hospitals that may attract more complex, sicker patients. The project will be composed of three phases during the next 3 years. During the first phase, criteria for case inclusion and data processing procedures have been finalized and the data set has been established. For the second phase, these data will be analyzed and a set of DRG's using updated patient information will be used to validate the categories. The last phase will involve the testing (and possible modification) of data from several hospitals in the Miami, Florida, area.

Prospective Payment in Rehabilitation Hospitals and Programs

Project No.:	15-C-98705/5-01
Period:	October 1984 - September 1985
Funding:	$ 724,000
Award:	Cooperative Agreement
Awardee:	Medical College of Wisconsin/Rand Corporation 1000 North 92nd Street, Room 2166 Milwaukee, Wis. 53226
Project Officer:	John C. Langenbrunner Division of Reimbursement and Economic Studies

Description: A cooperative agreement was awarded, effective October 1984, to the Medical College of Wisconsin (MCW) to obtain rehabilitation patient-record and cost data from approximately 8,000 medical charts at 100 rehabilitation hospitals and units across the Nation. The Rand/University of California, Los Angeles, Health Financing Policy Research Center designed the MCW data collection project and conducted the analysis required to investigate the feasibility of a case-mix classification system for Medicare reimbursement of medical rehabilitation hospitals.

Status: Section 603 of Public Law 98-21, Social Security Amendments of 1983, calls for studies incorporating exempt hospitals (such as rehabilitation hospitals) into the Medicare prospective payment system (PPS) by December 31, 1985. The project will provide findings that will assist the Health Care Financing Administration in considering a PPS for rehabilitation hospitals within this time limit.

The Rand/MCW research results indicate that:

- Differences to date, in average length of stay and charges, exist among types of rehabilitation facilities, with hospitals generally exhibiting longer stays and lower per diem charges.
- The vast majority (approximately 85 percent) of rehabilitation patients are received from acute-care hospitals.
- Three conditions—stroke, hip fractures, and arthritis—account for approximately two-thirds of rehabilitation services for the Medicare elderly.
- Functional status and additional measures of patient condition predict resources in expected directions.
- Multivariate analysis of diagnostic condition, functional status, and additional patient-level measures explain one-third of the variation in charges for rehabilitation stays.

Learning From and Improving Diagnosis-Related Groups for End-Stage Renal Disease Patients

Project No.:	14-C-98596/3-01
Period:	September 1984 - August 1986
Funding:	$ 350,000
Award:	Cooperative Agreement
Awardee:	The Urban Institute/Health Policy Center 2100 W. Street, NW. Washington, D.C. 20037
Project Officer:	Paul W. Eggers Division of Beneficiary Studies

Description: The introduction of prospective payment by diagnosis-related groups (DRG's) has drastically altered the incentives in medical care. The purpose of this project is to study the responses of providers at the level of individual patients and diagnoses in end-stage renal disease, an area on which abundant data are available. Specific issues to be addressed include the possibility of selection of diagnoses to maximize reimbursement, alteration of discharge and admission patterns and other forms of cost shifting, and the selection of patients for admission. Specifically, patients will be characterized in terms of major demographic and prognostic factors, including measures of severity of illness. Patterns of diagnostic categorization, admission patterns, and treatment costs will be compared for homogenous groups before and after the prospective payment system.

Status: Analytical files have been created and analysis has begun. Interim findings are expected in Spring 1986.

Response of Massachusetts Acute-Care Hospitals to the Massachusetts Cost-Containment Act

Project No.:	15-C-98635/1-01
Period:	December 1984 - November 1985
Funding:	$ 167,758
Award:	Cooperative Agreement
Awardee:	Tufts University School of Medicine 136 Harrison Avenue Boston, Mass. 02111
Project Officer:	Patricia Willis Division of Reimbursement and Economic Studies

Description: This study will assess the impact of the Massachusetts Cost-Containment Act (Chapter 372 of the General Laws) on the behavior of acute-care hospitals. In particular, the study will examine the effectiveness of the strategies devised by the hospitals to circumvent the cost restrictions, the internal adjustment processes (e.g., reductions in personnel, laboratories, and other activities) adopted to cope with the level of resource constraints imposed on the hospitals, and the responses to the constraints of hospital managers and professionals and the public that are recorded in the media. The study will contrast the impact of the Massachusetts regulatory environment to other State health cost environments that are less regulated. The study may investigate other strategies for health care cost containment—for example, the sources of wide geographical differences in costs among similar hospitals.

Status: This study will be funded for the first year only. The initial year concentrates on the acquisition of the Health Care Financing Administration patient-billing and cost-report data bases. Foundation funding will be sought for the subsequent phases of the project.

Annual Reports to Congress on the Impact of the Medicare Hospital Prospective Payment System

Funding: Intramural
Project Director: Stuart Guterman
Division of Reimbursement and Economic Studies

Description: Section 603 of Public Law 98-21 requires the Secretary of Health and Human Services to study and report annually to Congress on the impact of the Medicare prospective payment system (PPS) for hospitals. These reports to Congress, beginning in 1984 and ending in 1987, are to focus on the impact of PPS on classes of hospitals, beneficiaries, and other payers for inpatient hospital services, and, in particular, on the impact of computing diagnosis-related groups prospective payment rates by census division, rather than exclusively on a nationwide basis.

Status: The first annual report includes a discussion of the background of the Medicare hospital prospective payment system (PPS), an outline of the objectives of this multi-year evaluation effort, and a presentation of preliminary findings from the first year of the PPS. The second annual report will further analyze some of the findings from the first year of PPS, as well as presenting data from the second year of the new payment system. In addition, several additional topics (as discussed in the following project write-up) are to be addressed in the second annual report, according to congressional mandate. The remaining annual reports are to continue the analysis begun in the first two reports and address the additional issues specified in the congressional mandate.

Studies of Issues to be Included in the 1985 Annual Report to Congress

Funding: Intramural

Description: Section 603 of Public Law 98-21 requires the Secretary of Health and Human Services to include the results of the following studies in the Annual Report to Congress for 1985:

- The feasibility and impact of eliminating or phasing out separate urban and rural prospective payment rates for diagnosis-related groups (DRG's).
- Whether and how hospitals not currently paid according to the prospective payment system (PPS) methodology under Medicare can be paid on a prospective payment basis.
- The appropriateness of the PPS methodology for compensating hospitals for the additional expenses of outlier cases, and the advisability and feasibility of applying severity of illness, intensity of care, or other modifications to prospective payment rates for DRG's.
- The feasibility and desirability of applying the PPS methodology to payment by all payers for inpatient hospital services.
- The impact of PPS on hospital admissions, and the feasibility of making a volume adjustment in the prospective payment rates for DRG's or requiring preadmission certification to minimize the incentive to increase admissions.

Topic: Urban/Rural Rates
Project Director: Philip Cotterill
Division of Reimbursement and Economic Studies

Status: In addition to the mandate under Public Law 98-21, Public Law 98-369 requires reports on several other urban/rural issues. Because of the interrelationships among the issues, a single urban/rural report is being prepared that addresses the following:

- Elimination of the urban and rural differential in standard payment amounts.
- Retention of regional standard payment amounts after the 3-year transition.
- Refinement of the ways in which standard payment amounts might be blended on a regional or DRG-specific basis.
- DRG-by-DRG variation in the labor share of payment that is adjusted by the wage index (to determine whether rural hospitals are disadvantaged in DRG's with high nonlabor costs).

The Health Care Financing Administration (HCFA) is conducting econometric and other analyses of the importance of various factors in explaining urban/rural and regional differences in hospital costs, investigating alternative ways of defining and adjusting the standard payment amounts on Medicare payments to different types of hospitals,

and conducting simulations of the effects of alternative ways of defining and adjusting the standard payment amounts on Medicare payments to different types of hospitals. The cost analyses are being conducted for HCFA by the Center for Health Economics Research under the cooperative agreement with the Brandeis University Health Policy Research Consortium.

Topic: Exempted Hospitals and Units
Project Directors: John C. Langenbrunner, Patricia Willis, and Stephen F. Jencks
Division of Reimbursement and Economic Studies

Status: The National Institute of Mental Health, with funds transferred from the Health Care Financing Administration (HCFA), awarded a contract during the third quarter of fiscal year 1984 for the investigation and development of alternative patient classification systems for psychiatric and alcohol and drug abuse hospitals and units. Additional studies on this topic, not funded by HCFA, are to be monitored. The National Association of Children's Hospitals and Related Institutions was awarded a cooperative agreement by HCFA during the fourth quarter of 1984 for the investigation and development of alternative pediatric classification systems. The Medical College of Wisconsin (MCW) was awarded a cooperative agreement by HCFA at the beginning of the first quarter of 1985 for the collection of patient record data in rehabilitation hospitals and units. The Rand Corporation/University of California, Los Angeles, Health Financing Policy Research Center is participating in the design of the MCW project and the development of alternative patient classification systems for rehabilitation facilities. The Brandeis University Health Policy Research Consortium is investigating the characteristics (e.g., geographical distribution) of long-stay hospitals. The Brandeis Consortium is also providing assistance in the development of a conceptual framework for consideration of the method of inclusion of these hospitals under prospective payment. A range of studies on all of these topics conducted outside the Department have also been monitored and will be reviewed and synthesized for the congressional report.

Topic: DRG Refinements
Project Director: Stephen F. Jencks
Division of Reimbursement and Economic Studies

Status: Intramural work in this area includes studies of the relative costliness of care to different classes of Medicare beneficiaries, the appropriateness and distribution of Medicare outlier payments, and the effect of removing nonacute care from a data base on the homogeneity of diagnosis-related groups (DRG's). Extramural work includes five projects at the Rand Corporation/University of California, Los Angeles, Health Financing Policy Research Center: the effect of the prospective payment system (PPS) on hospital accounting profits; comparison of alternative classification systems; review of literature on DRG's; study of possible patient "dumping" in response to PPS; and study of the effects of "decompressing" DRG weights. Extramural work at the Brandeis Consortium focuses on examination of variation in practice patterns across hospital types, physician specialties, and regions.

The Brandeis Consortium, through the Center for Health Economics Research, is conducting a study of variation in treatment patterns within DRG's, to be included in the congressional report. An intramural study of outlier payments is being conducted, and the Rand/UCLA Center is to conduct an expanded analysis of this issue.

Topic: All-Payer Methodology
Project Director: William J. Sobaski
Division of Reimbursement and Economic Studies

Status: The Brandeis Consortium has examined how State rate-setting systems which apply to all payers differ from Medicare's prospective payment system and how other payers (government and private) have employed DRG's in prospective payment for inpatient care, and have also examined available information on cost shifting under "all-payer" and "limited-payer" State systems.

Topic: Measuring and Controlling Impact on Hospital Admissions
Project Director: William J. Sobaski
Division of Reimbursement and Economic Studies

Status: The Rand/UCLA Center has conducted an analysis of the impact of Medicare prospective payment on hospital admissions, hospital incentives related to the volume of admissions, and relevant policy options.

Prospective Payment and Analytical Support Studies

Project No.: 500-85-0015
Period: September 1985 - September 1988
Funding: $ 5,241,322
Award: Contract
Contractor: Abt Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Stuart Guterman
Division of Reimbursement and Economic Studies

Description: This project is intended to provide survey design, data collection, and statistical analysis in support of the congressionally mandated annual report (Public Law 98-21) on the impact of the Medicare hospital prospective payment system (PPS), other congressionally mandated reports, and other PPS-related studies. Individual work assignments to be made throughout the project will focus on specific topics relevant to these studies and reports.

Status: As of September 30, 1985, four work assignments had been made under this contract:

- A project management work assignment, to provide resources for the planning and development of project activities.
- A data base development work assignment, to identify, locate, and obtain data relevant to the study of PPS impact issues, and to develop a project data base.
- A survey of hospital decisionmakers on the impact of the PPS, to obtain and analyze information on the new payment environment from responses by hospital administrators and staff members.
- An analysis of patient care effects of prospective reimbursement, to compile and analyze patient-level data on the relationship between prospective reimbursement and patient outcomes.

Disease-Specific Severity Adjustments to Diagnosis-Related Groups

Project No.:	**15-C-98833/6-01**
Period:	**January 1986 - December 1987**
Funding:	**$ 280,129**
Award:	**Cooperative Agreement**
Awardee:	**Tulane School of Public Health and Tropical Medicine 1430 Tulane Avenue New Orleans, La. 70112**
Project Officer:	**Joel H. Broida Division of Reimbursement and Economic Studies**

Description: This study is an empirical investigation of the efficacy of six different methods of adjusting for severity of illness in DRG's related to acute myocardial infarction. The purpose of the study is to determine the equity of the current DRG payments for patients suspected of having heart attacks. This is one of several studies designed to analyze the degree to which DRG's properly account for severity.

Status: This cooperative agreement was awarded in September 1985. The start date of the project is January 1, 1986. Some preliminary planning activities have been initiated.

Diagnostic Mix, Illness Severity, and Costs in Teaching and Nonteaching Hospitals

Project No.: 15-C-98835/1-01
Period: September 1985 - September 1987
Funding: $383,951
Award: Cooperative Agreement
Awardee: University Hospital
Health Care Research Unit
75 East Newton Street
Boston, Mass. 02118
Project Officer: Joel Bobula
Division of Reimbursement and Economic Studies

Description: This project will investigate two major policy questions related to payment for the indirect costs of medical education under the Medicare prospective payment system:

- Are there significant, systematic differences between teaching and nonteaching hospitals in the complexity of diagnoses and severity of illness within diagnosis-related groups?
- Once one has controlled for diagnostic complexity and illness severity, how much do the costs of teaching and nonteaching hospitals differ?

This study will investigate these questions using a data set of 4,500 patient records, including case-mix measures, costs, and additional patient-related measures. These data will be drawn from a sample of 15 acute-care hospitals in the greater Boston area, stratified by major teaching, minor teaching, and nonteaching hospitals.

Status: This project was funded in September 1985. The first progress report is expected in January 1986.

Prospective Payment System and Post-Hospital Care: Use, Cost, and Market Changes

Project No.: 18-C-98852/3-01
Period: September 1985 - March 1988
Funding: $ 706,118
Award: Cooperative Agreement
Awardee: Georgetown University
Center for Health Policy Studies
2233 Wisconsin Avenue, NW.
Washington, D.C. 20007
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: The purpose of the project is to determine how much the hospital prospective payment system (PPS) shifts care from the hospital to skilled nursing facilities (SNF's) and home health providers, and to analyze the impact of this shift on total costs to Medicare and on changes in SNF characteristics that are likely to cause an increase in use by Medicare beneficiaries in the future. Medicare claims will be analyzed to determine how PPS has affected total service use (hospital, SNF, and home health) and costs for hospitalized patients. In addition, SNF's will be surveyed to identify changes in nursing home patients, services, and market structure likely to affect Medicare use. The survey will be supplemented with data from the Medicare/Medicaid Automated Certification System, SNF cost reports, and other sources.

Status: This project began September 30, 1985, and is in its early developmental stage.

Impact of Medicare's Prospective Payment System and Private Sector Initiatives: The Blue Cross and Blue Shield Organization's Experiences

Project No.: 15-C-98757/5-01
Period: September 1985 - August 1987
Funding: $ 270,000
Award: Cooperative Agreement
Awardee: Blue Cross and Blue Shield Association
676 North St. Clair
Chicago, Ill. 60611
Project Officer: Stuart Guterman
Division of Reimbursement and Economic Studies

Description: This congressionally mandated study (Public Law 98-21) is intended to examine the impact of the Medicare prospective payment system (PPS) and Blue Cross/Blue Shield cost-containment strategies on the cost and use rate experience of the Blue Cross/Blue Shield plans, both nationally and on an individual basis. In addition, the interaction effect between the PPS and Blue Cross/Blue Shield cost-containment strategies is to be analyzed. National Blue Cross/Blue Shield data and data collected from individual Blue Cross/Blue Shield plans are to be used in the study, supplemented by secondary data from other sources.

Status: Initial analysis of trends in cost and utilization rates for Blue Cross/Blue Shield plans has begun. Data are being assembled for use in the detailed analysis.

Swing Bed

Evaluation of National Rural Swing-Bed Program

Project No.:	500-83-0051
Period:	September 1983 - November 1987
Funding:	$ 1,002,248
Award:	Contract
Contractor:	Center for Health Services Research University of Colorado Health Sciences Center 1355 South Colorado Boulevard Denver, Colo. 80222
Project Officer:	Herbert A. Silverman Division of Program Studies

Description: This project is congressionally mandated by the Omnibus Reconciliation Act of 1980 (Public Law 96-499). The legislation permits hospitals with fewer than 50 beds that are located in rural areas with a shortage of long-term care beds to "swing" their beds between acute and long-term care as needed. The evaluation will assess the impact on:

- Access to long-term care beds in rural areas.
- Quality of long-term care in hospitals.
- Cost of services in swing-bed hospitals.
- Program-wide costs.
- Administrative costs to administer and monitor the program.

Based on the findings and recommendations, Congress will decide whether to continue the program or extend it to larger hospitals.

Status: The data collection is proceeding on schedule and a report is expected in mid-1986. The contract was modified to analyze the impact of the hospital prospective payment system (PPS) on the swing-bed hospitals and on the overall program. A second report evaluating the impact of PPS is scheduled for November 1987. Delays in the issuance of instructions for the completion of Medicare cost reports covering periods following the start of PPS may require extension of the delivery schedule for the second report.

Case Mix

Measuring the Cost of Case Mix Using Patient Management Categories

Project No.:	18-P-97063/3-05
Period:	September 1978 - July 1984
Funding:	$ 1,166,846
Award:	Grant
Grantee:	Blue Cross of Western Pennsylvania One Smithfield Street Pittsburgh, Pa. 15222
Project Officer:	John T. Petrie Division of Reimbursement and Economic Studies

Description: This project developed a patient classification system that reflects the diverse hospital resources required to manage clinically distinct patient types. There were two major objectives: to define the array of hospital products or patient types treated by hospitals and to identify the costs of producing these products.

Status: The researchers have met these objectives by completing two distinct phases in the process of measuring case mix: identification of approximately 800 clinically homogeneous patient categories, called patient management categories (PMC's), and development of relative cost weights for each PMC based on the services that a panel of clinicians believed typical patients should receive. Two computer programs have been developed. One classifies hospital cases into PMC's, and the other assigns resource requirement weights to the PMC's. The researchers have also completed a three-volume final report. Volume I, Patient Management Categories, describes the development of patient management categories; the final report is available from the National Technical Information Service, accession number PB86101979/AS. Volume II, Patient Management Category Relative Cost Weights, describes the relative weights (one for each PMC) that reflect the cost of the physician-specified services; the final report is available from the National Technical Information Service, accession number PB86101987/AS. Volume III, Patients Management Paths, is a pictorial description of the clinical management strategies, each of which consists of diagnostic and treatment services for a patient type; it is available only from Blue Cross of Western Pennsylvania.

Diagnosis-Related Groups Refinement for Nursing Care

Project No.:	15-C-98421/7-02
Period:	August 1983 - June 1985
Funding:	$ 369,650
Award:	Cooperative Agreement
Awardee:	American Nurses' Association, Inc. 2420 Pershing Road Kansas City, Mo. 64108
Project Officer:	Patricia Willis Division of Reimbursement and Economic Studies

Description: This congressionally mandated study (Public Law 98-21) investigated the relative structure of hospital nurse staffing resources across 20 high-volume diagnosis-related groups (DRG's) in two Milwaukee area hospitals. The data included standard abstract and cost information for all hospital stays during the period April 1 - September 30, 1984. Additionally, the data included daily measures of Medicus points indicating nurse staffing requirements and of "nursing diagnosis" items describing patient care requirements. These data were analyzed to compare the relative distribution of nursing resources as measured by the Medicus instrument with the relative weights of the current DRG system. The study attempted to relate statistically the Medicus measure, which has been reliably correlated to nursing resource intensity, and the nursing diagnosis items.

Status: This study was awarded because of the Health Care Financing Administration's interest in nursing resource issues in the policy context of the new prospective payment system (PPS). The findings represent a pilot effort to assess the extent to which the current DRG classification system equitably distributes Medicare reimbursement for nursing resource requirements. A final report was received in June 1985. The final report evaluates the policy implications of the findings for the allocation of hospital nursing resources in the context of the new PPS for Medicare.

Diagnosis-Related Groups Refinement Using Measures of Disease Severity

Project No.: 18-C-98761/9-01
Period: September 1985 - August 1986
Funding: $ 325,000
Award: Cooperative Agreement
Awardee: SysteMetrics, Inc.
104 West Anapamu Street
Santa Barbara, Calif. 93101
Project Officer: Timothy F. Greene
Division of Reimbursement and Economic Studies

Description: The objective of the project is to refine the diagnosis-related groups (DRG's) system to better account for variation in disease severity and to thereby develop a system that could increase the equity of hospital reimbursement under the Medicare prospective payment system. Alternative patient groupings that will make refinements to current DRG's will be developed, based on stage of disease, unrelated comorbidity, and age. The disease-staging methodology developed by the awardee will be used to measure stage of disease. Unrelated comorbidities (secondary medical problems) which increase resource requirements of hospitalization will be identified. The alternative groupings will be validated and compared with current DRG's.

Status: The study was recently awarded and has been revised to reflect the Office of Research and Demonstrations' research priorities and data availability. The awardee is currently completing preparation of an analysis file for identification of DRG's needing refinement.

Methods to Improve Case Mix and Severity of Illness Classification for Use in the Medicare Prospective Payment System

Project No.:	18-C-98840
Period:	September 1985 - August 1988
Funding:	$ 926,613
Award:	Cooperative Agreement
Awardee:	The Health Data Institute Seven Wells Avenue Newton, Mass. 02159
Project	Patricia Willis Division of Reimbursement and Economic Studies

Description: This congressionally mandated study (Public Law 98-21) will undertake several activities for improving the diagnosis-related groups (DRG's) classification system. The overall project objectives are to:

- Develop methods to improve the Health Care Financing Administration (HCFA) case mix and severity classification system by conducting empirical, applied policy research designed to determine what administrative improvements can readily be made to the current Medicare classification and prospective payment system and what additional clinical data may be useful for adjusting for severity of illness.

- Develop and make accessible to HCFA researchers a data base suited to investigate possible alternatives to existing HCFA reimbursement policies, including hospital diagnosis-related groups (DRG's), physician DRG's, and capitation formulas.

The awardee will primarily undertake this work with the Colorado Medicare data base with its integrated Part A and Part B processing and will supplement this with selected clinical measures abstracted from a sample of patient records in Boston hospitals.

Status: In September 1985, the awardee began negotiating to obtain Colorado Blue Cross and Blue Shield Medicare Part A and Part B files. Analyses will begin after these files are obtained. A series of interim reports are planned.

Children's Hospital Case-Mix Classification System Project

Project No.:	95-C-98570/3-01
Period:	July 1984 - December 1985
Funding:	$ 395,000
Award:	Cooperative Agreement
Awardee:	National Association of Children's Hospitals and Related Institutions 325 First Street Alexandria, Va. 22314
Project Officer:	John C. Langenbrunner Division of Reimbursement and Economic Studies

Description: This study has three objectives. The first objective is to evaluate the extent to which diagnosis-related groups (DRG's) define homogenous groupings of pediatric patients across different hospital settings, including children's hospitals. The second objective is to evaluate the extent to which other case-mix classification systems define homogenous groupings of pediatric patients across different hospital settings, including children's hospitals, and based on the strengths and weaknesses of the various systems, to develop a refined pediatric classification system. Alternative classification systems to be considered are disease staging, severity of illness, patient management categories, and pediatric diagnostic system—a system under initial development by five California children's hospitals. The third objective is to verify or modify the refined pediatric classification system based on detailed cost information, and to evaluate the manner and extent to which the refined pediatric classification system can best be incorporated into prospective payment for pediatric discharges.

Status: This study was awarded because of the Health Care Financing Administration's interest in pediatric case-mix classification issues in the policy context of the new prospective payment system. Findings from the first phase of the study established that:

- Children's hospitals are very similar in case-mix and resource intensity to university teaching hospitals with pediatric residencies.
- Children's hospitals and pediatric residencies treat a broader mix of pediatric conditions.
- Children's hospitals and residencies treat certain childhood conditions no more, and perhaps less, expensively than community hospitals.
- Children's hospitals and residencies treat virtually all of certain pediatric conditions, such as cardiac surgery.

The remaining analytic results of this study are scheduled for delivery at the end of the project period. The topic of including children's hospitals into the current DRG's will be part of the Report to Congress on the feasibility of paying hospitals currently excluded from the Medicare hospital prospective payment system on a prospective basis (mandated by Public Law 98-21).

Capital

Medicare-Medicaid Payment Policies and Capital Formation

Project No.: 18-C-98267/1-02
Period: April 1983 - December 1985
Funding: $ 282,671
Award: Cooperative Agreement
Awardee: Center for Health Economics Research
824 Boylston Street, Suite 104
Chestnut Hill, Mass. 02167
Project Officer: Joel Bobula
Division of Reimbursement and Economic Studies

Description: The objective of this project is to provide policymakers with new information on the effects of Medicare and Medicaid payment policies on hospital capital formation, past and future. First, the project will analyze the combined, overall effect of Medicare and Medicaid payment policies so that a policy can be designed that results in adequate, but not excessive, hospital investment in plant and equipment. Second, the project will analyze the impact of payment policies on hospital decisions to implement cost-saving or cost-inducing technologies. To complement these analyses, the following issues will be studied empirically:

- The effect of hospital dependence on Medicare and Medicaid revenues on hospital financial status and capital formation.
- The effects of alternative payment policies, especially prospective payment, on capital formation.
- The relationships between Medicare and Medicaid payment policies, hospital competition, and capital formation.
- The effects of public payment policies on hospital closures and mergers.
- The adoption of cost-saving or cost-inducing technology.

Data to be used in the project includes the Abt national rate-setting Medicare cost report file of 2,500 hospitals covering the period 1970-79. Parallel analyses will be conducted using American Hospital Association data for the period 1974-82. These files are operational currently. Some additional data will be collected for small pilot studies.

Status: The awardee has prepared two discussion papers:

- "Treatment of Captial Costs in Four Medicare-Waivered States: Maryland, New Jersey, New York, and Massachusetts."
- "Capital Cost Reimbursement Options."

An interim report on the first year's activities under the cooperative agreement was received in August 1984. A final report is expected in December 1985.

Data Development and Analyses

Data for Hospital Cost Monitoring and Analysis of Hospital Costs

Project No.:	500-80-0066
Period:	September 1980 - September 1985
Funding:	$ 1,111,800
Award:	Contract
Contractor:	American Hospital Association 840 North Lake Shore Drive Chicago, Ill. 60611
Project Officer:	J. Michael Fitzmaurice Division of Reimbursement and Economic Studies

Description: This project obtains survey data from a set of hospitals that are surveyed monthly about their costs and activities. This serves as a prime source of outside data on the performance of hospitals and is used in Health Care Financing Administration (HCFA) analyses, research, and publications.

Status: To date, HCFA has received monthly "National Hospital Panel Survey Reports" and monthly "Community Hospital Statistics" through June 1985, which are available only from the American Hospital Association.

Financially Troubled Hospitals

Metropolitan Comprehensive Care Program: A Health Systems Organization Demonstration

Project No.: 11-P-97805/2-05
Period: September 1980 - September 1985
Award: Grant
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Rose M. Truax
Division of Hospital Experimentation

Description: The demonstration is designed to test a new financing and health care role for municipal hospitals. The demonstration is specifically targeted for the medically indigent and all other members of the East Harlem community. During the 5-year demonstration, which is based at Metropolitan Hospital, coverage will be provided to a maximum of 17,100 poor and near-poor residents of the community who are ineligible for Medicaid coverage under existing Federal/State regulations. The five critical components of the demonstration are:

- The case-management system.
- The reorganization of the hospital management and financial systems.
- The introduction of the Citycaid program.
- Improved screening for Medicaid, Citycaid, and other third-party insurance.
- The establishment of a State-qualified health maintenance organization (HMO).

Status: The focus of the first 3 years' activities was establishing administrative mechanisms and implementing organizational changes to support a case-management approach to medical care for an enrolled population. The fourth year focused on the planning and development of an HMO. The HMO application has been submitted to the State for approval. Enrollment levels have not been growing at the expected rate. As of June 30, 1984, there was a total of 4,696 enrollees in the project, of which 3,123 were Citycaid and 1,573 were Medicaid. The project ended September 28, 1985. A final report is due in December 1985.

A Proposal to Relieve Financial Distress at a Congested Urban Medical Center

Project No.:	11-P-97817/9-04
Period:	January 1981 - January 1985
Award:	Grant
Grantee:	California Department of Health Services 714-744 P Street Sacramento, Calif. 95814
Project Officer:	Rose M. Truax Division of Hospital Experimentation

Description: This 4-year demonstration project tests the cost effectiveness of a county health maintenance system with capitated reimbursement for the medically indigent population served at the Los Angeles County/University of Southern California Medical Center and a community health care center. The approach will demonstrate that:

- Financial viability can be achieved by the use of new "strategies" in the provision of patient care and methods of reimbursement.
- The hospital can serve as an effective case manager, reducing costs and improving health outcomes.

Status: The first 2 years of this project was a developmental phase. The project became operational February 1, 1983. There were 2,095 enrollees in the project as of October 1, 1984, 1,300 newly eligibles, and 795 currently eligible Medicaid recipients. The project was expanded to include a second community health center in January 1984. This project ended on January 15, 1985. A final report is expected in December 1985.

Skilled Nursing Facility Prospective Payment

Alternative Nursing Home Reimbursement Systems for Medicare

Project No.:	16-C-98274/3-01
Period:	January 1983 - September 1986
Funding:	$ 350,601
Award:	Cooperative Agreement
Awardee:	The Urban Institute 2100 M Street, NW. Washington, D.C. 20037
Project Officer:	Philip Cotterill Division of Reimbursement and Economic Studies

Description: This study analyzed alternative approaches to prospective payment for Medicare skilled nursing facilities (SNF's) and investigated administrative factors that affect the efficiency of patient-related, rate-payment systems. The data used in this study were derived from 1980 Medicare cost reports and the Medicare/Medicaid Automated Certification System. The merging of these files produced a data base which included 3,492 of the 4,900 Medicare certified SNF's filing cost reports in 1980. These sample facilities accounted for roughly seven-eighths of all Medicare patient days provided that year.

Status: This project provided much of the technical analysis contained in the report, "Study of the Skilled Nursing Facility Benefit Under Medicare," that was submitted to the Congress in January 1985. In addition, results from this project were published in an article and a working paper:

- "State Rate-Setting and Its Effects on the Cost of Nursing Home Care," Journal of Health Politics, Policy and Law, Vol. 9, No. 4, Winter 1985.
- "Cost and Case-Mix Differences in Hospital-Based and Freestanding Skilled Nursing Facilities," Working paper, Urban Institute 3267-01, April 1984.

Analysis of the Medicare cost reports of skilled nursing facilities has shown that several proxy measures of case mix are important factors in explaining differences in SNF per diem costs. Higher costs are associated with a greater percentage of Medicare days, a higher number of admissions per bed, and greater nursing hours per inpatient day. These factors may indicate facilities with a greater orientation towards the short-term, rehabilitative Medicare patient. They only partially explain the higher costs observed for hospital-based, as opposed to freestanding, SNF's. The project has been extended through September 1986 to assist HCFA in analyzing options for SNF prospective payment under Medicare.

Longitudinal Study of the Impact of Prospective Reimbursement Under Medicaid on Nursing Home Care in Maine

Project No.:	18-C-98307/1-03
Period:	June 1983 - June 1986
Funding:	$ 467,314
Award:	Cooperative Agreement
Awardee:	University of Southern Maine Human Services Development Institute 246 Deering Avenue Portland, Maine 04102
Project Officer:	Judith Sangl Division of Reimbursement and Economic Studies

Description: This project studies the recently implemented nursing home prospective reimbursement system in Maine. The study will provide a longitudinal evaluation of the design and implementation of the system for intermediate care facilities in the State and of the system's effectiveness in achieving the policy goals of containing costs, maintaining or improving quality, and ensuring access to nursing home care by Medicaid recipients. The study consists of three major components:

- An impact analysis of the effects of prospective reimbursement on costs, quality, and access.
- A case study of the politics of the implementation of prospective reimbursement.
- An analysis of organizational and management response of nursing home administrators to the changes resulting from prospective reimbursement.

The hypotheses of the study are closely tied to the objectives of recently passed reimbursement legislation which includes incentives for maintaining and increasing Medicaid patient load. The awardee will try to measure immediate versus long-term effects of the new system on costs to the State.

Status: Major project activities are:

- Survey of nursing home administrators and directors of nursing regarding the industry's response to the new reimbursement system.
- Collection of patient-assessment data for the case-mix measures, and nursing home licensure and certification survey data for measures of quality of care.
- Collection of historical cost-report data for 3 years prior to and 1 year during implementation of the prospective reimbursement system.

A second survey of nursing home administrators and directors of nursing has begun. Collection of audited cost-report data for post-implementation years is continuing. Preliminary analyses have begun using currently available data. The final report is expected in late 1986. Based on this work, two draft reports have been prepared:

- "The Development and Implementation of Maine's Nursing Home Prospective Payment System."
- "Management Responses to Maine's Nursing Home Prospective Payment System."

New York State Case-Mix, Prospective Reimbursement System for Long-Term Care

Project No.:	11-C-98325/2-03
Period:	August 1983 - August 1986
Funding:	$ 416,012
Award:	Cooperative Agreement
Awardee:	New York State Department of Social Services 40 North Pearl Street Albany, N.Y. 12243
Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: The New York State Department of Social Services was awarded a Section 1115 grant, effective August 7, 1983, to develop, test, and refine a long-term care prospective reimbursement system based on clusters of patient characteristics. This is a 3-year cooperative agreement being conducted by the New York State Department of Health and Rensselaer Polytechnic Institute. The system builds on the results of research conducted at Yale University which developed clusters of patients in relation to staff resources used (Resource Utilization Groups or RUG's). The purpose of the project is to promote efficiency by associating payment levels with patient characteristics that indicate the amount of actual resources used by patients.

Status: During the first year, the RUG's were revised and tested. The result is a classification system (RUG's II) that accounts for 52 percent of the variance of nursing and other staff resources used by patients. RUG's II uses five clinical groupings and an activities of daily living (ADL) sum to develop 16 distinct resource utilization groupings. During the second year, the case-mix "weight" for each of the groups was developed. A short patient-review form was designed and tested along with an audit process. The basic design of the reimbursement system has been developed and includes:

- A price-based payment system with two major components, one of which is patient care.
- A system to review all patients in a facility every 6 months and all new admissions quarterly.
- A concurrent audit system.

Regulations have been formulated and approved. All patients in long-term care facilities have been reviewed once for initial rate-setting purposes. The RUG's have been compared with three other case-mix measures and researchers have reported 93 percent agreement between the data sets.

Resource Utilization Groups: Validation and Refinement of a Case-Mix System for Long-Term Care Reimbursement

Project No.:	18-C-98499/1-01
Period:	July 1984 - March 1986
Funding:	$ 248,924
Award:	Cooperative Agreement
Awardee:	Yale University School of Organization and Management New Haven, Conn. 06520
Project Officer:	Marni Hall Division of Reimbursement and Economic Studies

Description: This project continues Yale's prior work (also supported by the Health Care Financing Administration), which developed the resource utilization groups (RUG's) classification system for residents of long-term care facilities. This project will refine the original RUG's and correct deficiencies, e.g., the inclusion of some process variables, instead of just clinical variables, and reliance on subjective estimates of staff time. Unlike the prior project, it will take into account the rate at which patients' conditions change.

Status: This project has developed a revised five-group RUG's model. Validation of this model is under way using data from New York State and the National Center for Health Services Research. Work is under way to develop RUG's for rehabilitation services, and to develop and test models for analysis of rate of change of case mix. The final report is expected in March 1986.

Case-Mix Measure for Long-Term Care Medicare Patients

Project No.:	18-C-98581/2-01
Period:	July 1984 - March 1986
Funding:	$ 253,199
Award:	Cooperative Agreement
Awardee:	Rensselaer Polytechnic Institute School of Management Troy, N.Y. 12181
Project Officer:	Marni Hall Division of Reimbursement and Economic Studies

Description: This project is a continuation of work begun under a Health Care Financing Administration-sponsored Yale University grant to develop resource utilization groups (RUG's) for long-term care patients. The RUG's contain individuals with similar resource consumption. The original set of RUG's was developed by using mostly Medicaid patients. This project will develop RUG's for Medicare skilled nursing facility patients. The role of diagnostic variables and service/treatment variables as part of the classification system will be evaluated. This project will also develop relative case-mix weights for each classification.

Status: Data collection for this project was completed in May 1985, and development of Medicare RUG's is now in progress. The final report is expected in Spring 1986.

Texas Long-Term Care Case-Mix Reimbursement Project

Project No.:	11-C-98688/6-02
Period:	September 1984 - September 1986
Funding:	$ 272,494
Award:	Cooperative Agreement
Awardee:	Texas Department of Human Resources 701 West 51st Street Austin, Tex. 78769
Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: The Texas Department of Human Resources was awarded a 2-year cooperative agreement effective September 30, 1984, to develop and test a prospective case-mix reimbursement methodology for long-term care facilities. Case-mix reimbursement involves assessment of patient characteristics associated with various patterns of service needs and reimbursement at a rate appropriate to that need. The case-mix reimbursement methodology will reflect institutional case mix and the associated costs of service. The purpose of the project is to develop a more equitable payment system for long-term care providers than the current flat-rate system for reimbursement of skilled nursing and intermediate care facilities services. The system will build on the results of research conducted in the State of New York. It will include the collection of patient characteristics and staff time measurement for 2,000 patients. The researchers will also study the long-term care reimbursement systems in Illinois, Maryland, Ohio, and West Virginia, to identify potential problems in implementing a case-mix reimbursement system.

Status: The cooperative agreement was awarded in September 1984. The State has hired a project staff and has met extensively with the other States that utilize nursing home case-mix payment systems. A chart has been completed comparing the assessment variables used by the other case-mix States. The State has drafted an assessment instrument and sent it to other researchers for comment. They expect to begin data collection on patient characteristics and staff time in early 1986.

Evaluability Assessment of the Medicare Prospective Payment System on Long-Term Care

Project No.:	100-84-0032
Period:	October 1984 - December 1985
Funding:	$ 129,891
Award:	Contract
Contractor:	Urban Institute 2100 M Street, NW. Washington, D.C. 20037
Project Officer:	Marni Hall Division of Reimbursement and Economic Studies

Description: This project is funded by the Office of the Assistant Secretary for Planning and Evaluation. The role of the Office of Research and Demonstrations is to serve on a Departmental work group which provides ongoing technical direction and review of the work produced. The purpose of this study is to develop an evaluation strategy for investigating the impact of the Medicare prospective payment system (PPS) on the long-term care population and the long-term care system. The contractor is responsible for identifying potential patient, facility, and system-level changes that may result from the implementation of the PPS. This study will examine the extent and the manner in which the implementation of PPS has altered demand, utilization, and expenditures for long-term care services. The contractor is also developing methodologies for examining the impact of those changes.

Status: Two reports have been developed under this contract:

- "Analysis of Data Bases for Studying the Impact of PPS on Long-Term Care."
- "PPS and Long-Term Care: Data and Research Strategies among States, Peer Review Organizations, and Providers."

The draft final report has been received and is currently under review.

Home Health

Home Health Agency Prospective Payment Demonstration

Project No.:	500-84-0021
Period:	December 1983 - December 1988
Funding:	$ 2,523,559
Award:	Contract
Contractor:	Abt Associates, Inc. 1055 Thomas Jefferson Street, NW. Washington, D.C. 20007
Project Officer:	William Saunders Division of Long-Term Care Experimentation

Description: The purpose of this project is to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the Medicare and Medicaid programs. The demonstration will enable the Health Care Financing Administration to evaluate the effects of various methods of prospective payment on Medicare and Medicaid expenditures, quality of home health care, and home health agency operations.

Status: A contract was awarded in December 1983 to Abt Associates for development and implementation of the demonstration. The initial phase of the project involves the development of the specific payment methodologies; establishment of a research design and evaluation strategy; design of a process to monitor the quality of care provided under the demonstration; development of data collection and status reporting plans; and identification, selection, and training of participating home health agencies. The payment methodologies will then be tested for 3 years to determine the effects on Medicare and Medicaid expenditures, quality of care, and home health agency operations. The implementation of the demonstration has been delayed pending approval of waivers of the Medicare statutory and regulatory requirements necessary to conduct the demonstration.

Development of Home Health Agency Competitive Bidding Models

Project No.:	500-84-0033
Period:	June 1984 - January 1986
Funding:	$ 267,079
Award:	Contract
Contractor:	Center for Health Policy Studies, Inc. 5865 Robert Oliver Place Columbia, Md. 21045
Project Officer:	William Saunders Division of Long-Term Care Experimentation

Description: This project is mandated by Section 6 of the Orphan Drug Act, Public Law 97-414. In the interest of testing purchasing and payment methods that would bring competitive market forces into the health care field, the Health Care Financing Administration has awarded a contract for the development of several models of competitive bidding for home health services under Medicare and Medicaid.

Status: A contract was awarded in June 1984 to the Center for Health Policy Studies to develop several alternative competitive bidding models. The contractor will also develop a research design and evaluation strategy for a possible subsequent demonstration project to test the bidding models. Two reports have been completed:

- "Review of the Literature and Experience of Competitive Bidding for Health Care Services," January 1985.
- "Market Study for Home Health Care Services," February 1985.

The project has been extended until January 1986 to provide the contractor with additional time to complete two reports. These reports will provide a detailed description of the bidding models and the proposed demonstration project.

Hospice

Medicare/Medicaid Hospice Demonstration

Period: October 1980 - March 1985

Description: This demonstration was designed to gather data on the cost, utilization, and quality of hospice care with major emphasis on the provision of home care services (for example, continuous nursing care and prescription drugs). There were 26 sites, and each site provided care to terminally ill Medicare beneficiaries and Medicaid recipients having a life expectancy of 6 months or less. An interdisciplinary team approach was utilized to maintain the patient at home in a comfortable, alert, and pain-free state.

Status: Because Public Law 97-248 mandated a Medicare hospice benefit and the extension of the demonstration, each site continued to enroll Medicare beneficiaries until September 30, 1984. The Medicaid portion of the project ended September 30, 1983, and the Medicare component ended March 30, 1985. The number of Medicaid participants was unexpectedly small, approximately 363 persons. In contrast, Medicare enrollments were substantial throughout the demonstration, totaling an estimated 15,000 beneficiaries by September 30, 1984. The Medicare portion of the demonstration was systematically phased out as the project sites became Medicare certified hospice providers. The final evaluation report by the independent evaluator, Brown University, should be available in Summer 1986.

Project No.:	95-P-50109/9-02
Award:	Grant
Grantee:	Santa Barbara Visiting Nurse Association 401 North Milpas Street Santa Barbara, Calif. 93103
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50022/9-02
Award:	Grant
Grantee:	San Diego Hospice Corporation 3840 Calle Fortunada, Suite 100 San Diego, Calif. 92123
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50194/9-02
Award:	Grant
Grantee:	Hospice of Marin 77 Mark Drive, #16 San Rafael, Calif. 94903
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50148/9-02
Award:	Grant
Grantee:	San Pedro Peninsula Home Care 1386-B West Seventh Street San Pedro, Calif. 90732
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50149/9-02
Award:	Grant
Grantee:	Hospital Home Health Care Agency of California 23456 Hawthorne Boulevard, Bldg. 5 Torrance, Calif. 90505
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50020/8-02
Award:	Grant
Grantee:	Boulder County Hospice, Inc. 2825 Marine Street Boulder, Colo. 80303
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50037/1-02
Award:	Grant
Grantee:	The Connecticut Hospice, Inc. 61 Burban Drive Branford, Conn. 06405
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50120/4-02
Award:	Grant
Grantee:	Hospice, Inc. 111 NW. 10th Avenue Miami, Fla. 33128
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50079/4-02
Award:	Grant
Grantee:	Hospice Care, Inc. 3400 70th Avenue North Pinellas Park, Fla. 33565
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.: 95-P-50083/1-02
Award: Grant
Grantee: Hospice of the Good Shepherd, Inc.
P.O. Box 144
Waban, Mass. 02168
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50085/1-02
Award: Grant
Grantee: University of Massachusetts Medical Center
Palliative Care Service, Inc.
55 Lake Avenue North
Worcester, Mass. 01605
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50154/5-02
Award: Grant
Grantee: Bethesda Lutheran Medical Center
559 Capitol Boulevard
St. Paul, Minn. 55103
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50122/7-02
Award: Grant
Grantee: Lutheran Medical Center
2639 Miami Street
St. Louis, Mo. 63118
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50001/2-02
Award: Grant
Grantee: Overlcok Hospital
193 Morris Avenue
Summit, N.J. 07901
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50135/6-02
Award: Grant
Grantee: Hospital Home Health Care, Inc.
500 Walter NE., Suite 310
Albuquerque, N.Mex. 87102
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50006/2-02
Award: Grant
Grantee: Cabrini Hospice
227 East 19th Street
New York, N.Y. 10003
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50111/2-02
Award: Grant
Grantee: Genesee Region Home Care Association
311 Alexander Street
Rochester, N.Y. 14604
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50267/0-02
Award: Grant
Grantee: Providence Medical Center
4805 NE. Glisan
Portland, Oreg. 97213
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50068/6-02
Award: Grant
Grantee: Visiting Nurse Association of Dallas
8200 Brookriver Drive, Suite 200N
Dallas, Tex. 75247
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50147/6-02
Award: Grant
Grantee: King William Health Center
323 East Johnson
San Antonio, Tex. 78204
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.: 95-P-50040/1-02
Award: Grant
Grantee: Northern Vermont Respond
Visiting Nurse Association, Inc.
260 College Street
Burlington, Vt. 05401
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Project No.:	95-P-50043/3-02
Award:	Grant
Grantee:	Hospice of Northern Virginia, Inc. 4715 North 15th Street Arlington, Va. 22205
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50182/3-02
Award:	Grant
Grantee:	Medical College of Virginia Box 37, MCV Station Richmond, Va. 23298
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50104/0-02
Award:	Grant
Grantee:	Community Home Health Care 190 Queen Anne Avenue North Seattle, Wash. 98109
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50121/5-02
Award:	Grant
Grantee:	Bellin Memorial Hospital 744 South Webster Avenue Green Bay, Wis. 54305
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

Project No.:	95-P-50132/5-02
Award:	Grant
Grantee:	Rogers Memorial Hospital, Inc. 34810 Pabst Road Oconomowoc, Wis. 53066
Project Officer:	Dennis M. Nugent Division of Long-Term Care Experimentation

National Hospice Study

Project No.:	99-P-97793/1-03
Period:	September 1980 - June 1984
Funding:	$ 2,890,840
Award:	Grant
Grantee:	Brown University Division of Biology and Medicine Box G Providence, R.I. 02912
Project Officer:	Spike Duzor Division of Health Systems and Special Studies

Description: This study will evaluate the effects of providing hospice services to terminally ill Medicare and Medicaid patients. It will determine whether hospice care can provide the necessary emotional, psychological, and medical support to the terminally ill which would permit them to remain at home during their final months of illness and eliminate long and costly periods of institutionalization.

Status: The final report is currently being reviewed by the Health Care Financing Administration staff. It is anticipated that this report will be available in Winter 1986. Preliminary results indicate that the hospice concept favorably compares with traditional medical services for quality-of-life outcomes.

Implications of the National Hospice Study for Hospice Prospective Reimbursement

Project No.:	99-C-97793/1-04
Period:	May 1984 - September 1985
Funding:	$ 245,306
Award:	Cooperative Agreement
Awardee:	Brown University Box G Providence, R.I. 02912
Project Officer:	Feather Ann Davis Division of Beneficiary Studies

Description: The purpose is to conduct analyses of the interrelationships among the cost, quality of life, and patient characteristic data for the purpose of exploring alternative methods for prospective reimbursement. A composite case-mix adjustment, based on prior utilization, patient characteristics, and informal support factors was developed. Analyses were conducted to determine the feasibility of a unique, inpatient hospice, diagnosis-related group (DRG).

Status: The final report has been received and accepted.

Hospice Patient Outcomes and Quality of Care

Project No.: 18-C-98615/01
Period: July 1984 - December 1985
Funding: $ 123,870
Award: Cooperative Agreement
Awardee: Hebrew Rehabilitation Center for Aged
Department of Social Gerontological Research
1200 Centre Street
Boston, Mass. 02131
Project Officer: Feather Ann Davis
Division of Beneficiary Studies

Description: The purpose of this research is to contribute to knowledge concerning variations in hospice patient quality-of-life measures according to type of hospice setting, type of services provided, and other relevant variables. The overall goal is to use two longitudinal data sets to extrapolate findings concerning the relationship between program and personal characteristics, and variations in pain and other symptoms experienced by hospice patients as death approaches.

Status: Analytic work is under way and a final report is expected in Winter 1986.

Noncertified Hospice Cost Analysis

Project No.: 500-85-0038
Period: June 1985 - June 1987
Funding: $ 1,373,469
Award: Contract
Contractor: Jack Martin and Co.
30150 Telegraph Road, Suite 155
Birmingham, Mich. 48010
Project Officer: Feather Ann Davis
Division of Beneficiary Studies

Description: This congressionally mandated study (Public Law 97-248) is designed to collect annual cost data from a stratified random sample of 100 hospices that are not participating in the Medicare hospice benefit, to serve as a control group for the evaluation of the Medicare hospice benefit legislation.

Status: Final clearance for data collection is being sought from the Office of Management and Budget. Participation in the study is being solicited.

Population-Based Study of Hospice

Project No.:	18-C-98674/0-02
Period:	September 1984 - September 1987
Funding:	$ 450,712
Award:	Cooperative Agreement
Awardee:	Fred Hutchinson Cancer Research Center 1124 Columbia Street Seattle, Wash. 98104
Project Officer:	Feather Ann Davis Division of Beneficiary Studies

Description: This is a study of utilization among hospice and nonhospice terminal cancer patients; the effect of hospital prospective reimbursement on hospice case load and length of stay; and hospice penetration of the market. Seven data sets will be linked in order to provide both economy and power. The area under study is 13 counties in western Washington.

Status: The project was delayed about 6 months in start up because of delays in staff hiring and the processes of finalizing hospice participation. A data collection form has been pretested and training of data abstractors has begun. A revised analytic plan has been prepared.

The Nature, Process, and Modes of Hospice Care Delivery

Project No.:	500-85-0022
Period:	April 1985 - September 1986
Funding:	$ 376,474
Award:	Contract
Contractor:	Joint Commission on Accreditation of Hospitals 875 North Michigan Avenue Chicago, Ill. 60611
Project Officer:	Feather Ann Davis Division of Beneficiary Studies

Description: This project is congressionally mandated by the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). Surveys will be conducted of a representative sample of both Medicare certified and noncertified hospices in order to describe and to understand what care is being provided, how it is being provided, and by whom. The emphasis is on the qualitative and quantitative description of variations in the nature, characteristics, and processes employed by hospices as measured by the Joint Commission on Accreditation of Hospitals standards and associated requirements. It is the intent of this project to determine how representative Medicare-certified hospice providers are and the effects of certification on hospice care.

Status: The sample has been obtained and onsite surveys are under way. Clearance by the Office of Management and Budget for a mail survey has been received.

Title XVIII Hospice Benefit Program Evaluation (Medicare)

Project No.:	500-85-0024
Period:	April 1985 - March 1988
Funding:	$ 1,295,156
Award:	Contract
Contractor:	Abt Associates, Inc. 55 Wheeler Street Cambridge, Mass. 02138
Project Officer:	Feather Ann Davis Division of Beneficiary Studies

Description: This project is congressionally mandated by the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) and Deficit Reduction Act of 1984 (Public Law 93-369). The Secretary is required to prepare and transmit a report to Congress no later than January 1, 1986, which will determine "whether or not the reimbursement method and benefit structure...for hospice care under Title XVIII...are fair and equitable and promote the most efficient provision of hospice care...and any recommendations for legislative changes in the hospice care reimbursement or benefit structure." Specific information will be provided on the current prospective payment system for hospice. The evaluation will address congressional and departmental needs for information on the hospice benefit for making decisions regarding the extension and possible modification of the benefit and the reimbursement mechanism and for ongoing program operation. Materials from the contract will be used as partial input in the mandated Report to Congress, due January 1986. Additional reports will be prepared by January 1987 and January 1988.

Status: Analytic work is under way utilizing available Health Care Financing Administration 1984 administrative data on hospice patients and a comparison group of Medicare cancer patients who died in 1984. Analytic reports are due in December of 1985, 1986, and 1987.

PHYSICIAN PAYMENT

Data Development and Analyses

Analysis of Physician Pricing Behavior, Third-Party Administrative Practices

Project No.:	600-76-0058
Period:	April 1976 - September 1983
Funding:	$ 741,570
Award:	Contract
Contractor:	Harvard University School of Public Health 677 Huntington Avenue Boston, Mass. 02115
Project Officer:	William J. Sobaski Division of Reimbursement and Economic Studies

Description: This study deals with physician responses to reimbursement alternatives, including analysis of price trends, relative values, and relations between medicine and private health insurance.

Status: All interim reports were completed. A draft final report was received in Fall 1984. The study of price trends showed that wide disparities both within and across areas may be concealed by national price trend figures. A unique methodological approach to relative value studies was undertaken that showed large imbalances exist between payments for technological procedures versus primary care. The nonprofit and for-profit private insurance sectors were shown to employ quite different strategies in establishing relationships with medicine, albeit both cover positive relationships. A new model of supply-and-demand factor interactions in the medical market was developed. The final report is expected in late 1986.

Aspects of Physician Behavior in Medicare and Medicaid

Project No.:	95-P-97178
Period:	September 1978 - December 1983
Funding:	$ 730,313
Award:	Grant
Grantee:	The Urban Institute 2100 M Street, NW. Washington, D.C. 20037
Project Officer:	William J. Sobaski Division of Reimbursement and Economic Studies

Description: This project examines five areas of physician reimbursement:

- Provision of pathology services.
- Medicare and Medicaid reimbursement rates.
- The effect of reimbursement on physician practice location.
- Medicare Economic Index (MEI), which measures increases in general earnings levels and other expenses incurred by physicians.
- Simulation and analysis of alternative reimbursement systems.

Status: A final report was received in June 1985 and is under review. Major findings were:

- The Medicare lowest charge level program was a more effective constraint on prevailing charge levels than on customary charge levels for pathology services.
- If all 1983 Medicaid services had been paid at Medicare rates, payments to physicians would have risen from about $3.0 billion to $4.7 billion.
- Physicians tend to locate in higher income areas, especially over long time periods when the growth of physician per capita exceeds 5 percent.
- In 1978, the majority of physicians experienced only a modest decrease in Medicare revenues as a result of the MEI.
- Few physicians would experience a change of more than 10 percent in Medicare revenues if present areas and/or specialty differentials in prevailing charges were removed.
- Under an "all or none" assignment feature, in all likelihood, the increases in patient costs will not be offset by reductions in program costs.

Survey of Physicians' Practice Costs and Incomes: Redesign and Implementation

Project No.:	500-83-0025
Period:	June 1983-December 1985
Funding:	$ 1,508,942
Award:	Contract
Contractor:	National Opinion Research Center 6030 South Ellis Chicago, Ill. 60637
Project Officer:	Sherry A. Terrell Division of Reimbursement and Economic Studies

Description: This is the fifth national survey of physicians' practice costs and income periodically conducted since 1975. Approximately 5,000 physicians were surveyed about their 1983 practice patterns. The survey will update our knowledge of physician practice economics since the last survey in 1978. The survey will provide data for the assessment and refinement of the Medicare Economic Index, which measures increases in general earnings levels and expenses incurred by physicians. Other information relevant to a number of current physician payment issues, such as the extent of participating physicians and malpractice information, will be available.

Status: Interviewing was completed in May 1985. Data editing, cleaning, and test runs have been completed. A number of technical reports are being produced by the subcontractor, Health Economics Research, Inc. These will include descriptive analyses of participating physicians, prospective payment system impact, physician practice arrangements, and emergency room physician characteristics. Two final technical reports entitled, "An Analysis of Medicare's Physicians Participation Agreement Program," which was prepared by the subcontractor Health Economics, Inc., and "Physicians' Perceptions About the Short-Run Impact of Medicare's Prospective Payment System" were received in October 1985. A public use data tape, a detailed code book, and the final report are expected in early 1986. Once the reliability of the data tapes has been determined, the data tapes will be made available through the National Technical Information Service.

Medical Doctor Diagnosis-Related Groups Algorithms

Project No.:	500-84-0024
Period:	February 1984 - February 1985
Funding:	$ 114,931
Award:	Contract
Contractor:	Mandex, Inc. 8302D Old Courthouse Road Vienna, Va. 22180
Project Officer:	William J. Sobaski Division of Reimbursement and Economic Studies

Description: The principal purpose of this project was to obtain statistical algorithms that can be used to improve estimates of the values of physician service resources for inpatient care by diagnosis-related groups calculated from the 1981 Health Care Financing Administration (HCFA) statistical files. In addition, suggestions were made for calculating these values from the 1983 HCFA statistical files and for examining the specialty and locality of using national average payment amounts.

Status: The initial planning conference with the Office of Research, Office of Legislation and Policy, and Office of Statistics and Data Management staff was held February 8, 1984. Initial analysis of South Carolina carrier data has led to substantially improved matching of Medicare provider analysis and review and bill summary records being used for intramural studies. Recommendations for estimating cost weights from the inpatient hospital bill file and Part B Medicare data file linkage were received. Findings from the study based on the analysis of the merged carrier and intermediary data from two States—South Carolina and Florida—conclude that a physician diagnosis-related group system is not inconceivable. The contractor states that a few components necessary for the development of such a system are feasible, but the data at hand do not reveal whether such a system would be advisable. The project was completed in February 1985.

Further Analysis of the Medical Doctor Diagnosis-Related Groups Algorithms

Project No.: 500-85-0023
Period: April 1985 - January 1986
Funding: $154,734
Award: Contract
Contractor: Mandex, Inc.
8302D Old Courthouse Road
Vienna, Va. 22180
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: This project is an extension of Contract Number 500-84-0024. Section 603 of Public Law 98-21, the Social Security Amendments of 1983, required that the Department of Health and Human Services begin collecting data for calculating the cost of physician services related to inpatient care of beneficiary cases classified by diagnosis-related group (DRG), and to report on the feasibility of a DRG-like system for Medicare payment for such physician services.

Status: The contractor has completed the following tasks:

- A visit to South Carolina Blue Shield to obtain 5 years of Part A and B data.
- Acquisition of calendar year 1983 Part B Medicare data files (BMAD) from the Health Care Financing Administration's Bureau of Data Management and Strategy.
- Acquisition of 1983 and 1984 Medicare provider analysis and review (MEDPAR) files.

Mandex, Inc., has begun Part B analyses that include procedure-based analyses and physician practice-based analyses. The contractor is also engaged in BMAD analyses using 1983 and 1984 data. The contractor will continue the MD-DRG analyses using 1983, 1984, and 1985 MEDPAR data.

Payment Options for Nonphysician Anesthetists under the Prospective Payment System

Project No.:	17-C-98759/1-01
Period:	September 1985 - September 1987
Funding:	$ 281,167
Award:	Cooperative Agreement
Awardee:	Center for Health Economics Research 824 Boylston Street Chestnut Hill, Mass. 02167
Project Officer:	Rose M. Truax Division of Hospital Experimentation

Description: This project is a 2-year econometric study of the provision of anesthesia services to surgical patients in hospitals. The primary purpose of the project is to assist the Health Care Financing Administration in the preparation of a Congressionally mandated study (Public Law 98-369) of payment options that would not discourage the use of certified registered nurse anesthetists by hospitals.

The study will address two broad questions:

- What are the technically and economically efficient uses of nonphysician anesthetists as substitutes for and complements to anesthesiologists in providing hospital anesthesia services?

- What are the direction and magnitude of any changes in the use of nonphysician anesthetists that could be expected under each possible prospective payment system payment option?

Status: The project was funded at the end of fiscal year 1985. It is in the early developmental stage.

A National Study of Resource-Based Relative Value Scales for Physician Services

Project No.: 18-C-98795/1-01
Period: September 1985 - February 1988
Funding: $ 2,052,000
Award: Cooperative Agreement
Awardee: President and Fellows of Harvard College
Harvard School of Public Health
1350 Massachusetts Avenue, Holyoke Center 4th
Cambridge, Mass. 02138
Project Officer: Sherry A. Terrell
Divison of Reimbursement and Economic Studies

Description: Harvard and its subcontractors, the American Medical Association and the Center for Survey Research, will conduct a comprehensive study of the relative value of physicians' services. The purpose is to develop objective and reliable information on the resource inputs for medical procedures by physicians. Over a 30-month period, the group will develop a resources-based relative value scale (RBRVS) for approximately 200 procedures within and across medical and surgical specialties. The research team will use physician concensus groups and the Hsiao-Stason method of calculating resources based on complexity of services, time, practice expense, and specialty training. Also, a method for updating the relative values and fee structures will be developed.

Status: The cooperative agreement was awarded in September 1985. Basic systems are being put in place to convene the physician panels and initiate phase one of the project.

Impact of Medicare Fee Freeze and Participation Agreements on Physicians

Project No.: 18-C-98758/1-01
Period: September 1985 - August 1988
Funding: $ 975,747
Award: Cooperative Agreement
Awardee: Center for Health Economics Research
824 Boylston Street
Chestnut Hill, Mass. 02167
Project Officer: Terrence L. Kay
Division of Reimbursement and Economics Studies

Description: The project will undertake policy research on how physicians have responded to the Medicare physician fee freeze and participation agreement. Both of these provisions were established in the Deficit Reduction Act of 1984 (Public Law 98-369). A primary objective is to determine whether physicians increased the volume of services provided on the levels and mix of services during a 15-month period when their fees and Medicare reimbursements were frozen. The potential impacts of refinements to the way Medicare pays for physician services will also be examined.

Status: The award was made in September 1985. Initial data requests have been submitted. The data to be analyzed will include Part B paid claims from a national sample of all carriers over several years, and for 1984, all of the paid claims from seven carriers. Reports of interim findings are expected every 6-12 months.

Feasibility of Incorporating CPT-4 Codes for Physician Billing into the Diagnosis-Related Groups System for In-Hospital Medicare Surgical Patients

Project:	18-C-98631/5-01
Period:	August 1984 - July 1985
Funding:	$ 70,545
Award:	Cooperative Agreement
Awardee:	Mayo Foundation Department of Internal Medicine 200 First Street SW. Rochester, Minn. 55905
Project Officer:	William J. Sobaski Division of Reimbursement and Economic Studies

Description: This potential 19-month project was designed to show whether the CPT-4 surgical procedure codes used in billing physician services could be used in lieu of International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) procedure codes to classify inpatient surgical cases into diagnosis-related groups (DRG's). The researchers matched physician Medicare billing records with hospital discharge abstracts for more than 31,000 surgical cases performed at affiliated hospitals from 1981 to 1983. The merger was completed in more than 96 percent of these cases.

Status: A final report was received in December 1985. It concludes that it appears feasible to develop a DRG grouper for surgical patients in lieu of ICD-9-CM procedure codes. Between 68 and 88 percent of cases could be classified into the ICD-9-CM DRG when the CPT-4 surgical codes which predominate in each DRG were used in concert with other DRG grouping factors (diagnoses , age, sex, etc). However, much time and effort would be needed to develop a CPT-4 code-based grouper that would identically assign a high enough (more than 95 percent) proportion of CPT-coded cases to be feasible from an administrative basis in a high-volume health insurance program.

Creating Diagnosis-Related-Group-Based Physician Reimbursement Schemes: A Conceptual and Empirical Analysis

Project No.: 15-C-98387-/1-02
Period: September 1983 - June 1986
Funding: $ 503,424
Award: Cooperative Agreement
Awardee: Center for Health Economics Research
824 Boylston Street
Chestnut Hill, Mass. 02167
Project Officer: Stephen F. Jencks
Division of Reimbursement and Economic Studies

Description: Under this project, conceptual analyses will explore alternative diagnosis-related-group-based physician payment schemes, using alternative packaging methods developed under an earlier Health Care Financing Administration contract. Empirical analyses will be conducted using Medicare Part A and Part B data for New Jersey, North Carolina, and Michigan, and Medicaid data from New Jersey.

Status: A first-year report on data from North Carolina and New Jersey has been delivered. An interim report on data from all four States has been received. One article has been published from this study: "Physician diagnosis-related groups," New England Journal of Medicine, Vol. 313, 1985.

Economics of Diagnosis-Related-Group-Based Physician Reimbursement

Project No.: 18-C-98567/3-01
Period: July 1984 - October 1985
Funding: $ 154,966
Award: Cooperative Agreement
Awardee: Project Hope
Millwood, Va. 22646
Project Officer: Stephen F. Jencks
Division of Reimbursement and Economic Studies

Description: Project Hope will prepare a critical literary review and three papers on issues surrounding application of diagnosis-related groups to physician reimbursement, conduct a conference on Health Care Financing Administration-sponsored physician research, and conduct a small working conference on future research in this area.

Status: All papers are in preparation, drafts or outlines have been received, and a public conference on research was conducted in January 1985. A final report is expected in Summer 1986.

Prospective Payment of Physicians

Funding: Intramural
Project Director: Stephen F. Jencks
Division of Reimbursement and Economic Studies

Description: Section 603 of Public Law 98-21, Social Security Amendments of 1983, required that the Secretary, Department of Health and Human Services, during fiscal year 1984, begin the collection of data necessary to compute, by diagnosis-related groups (DRG's), the amount of physician charges for services furnished to hospital inpatients classified in those DRG's. A Report to Congress that includes recommendations on the advisability and feasibility of determining payment for inpatient physicians' services on a DRG-type classification was required for 1985.

Status: Data file construction and specification of data display tables to be produced began in June 1983. A cooperative agreement to study DRG-based physician reimbursement schemes was awarded to the Center for Health Economics Research in September 1983. Substantive work on the subject was also part of a cooperative agreement with the Brandeis University Health Policy Research Consortium and a cooperative agreement with Project Hope. Intramural and extramural work is essentially complete. A Report to Congress was prepared by the Office of Research and Demonstrations and is currently undergoing departmental review. Final reports are expected in 1986 from the Center for Health Economics Research and Project Hope. An article summarizing alternatives for physician payment by Medicare, "Strategies for reforming Medicare's physician payments," was published in New England Journal of Medicine, Vol. 312, 1985.

Malpractice Component of the Medicare Economic Index

Funding: Intramural
Project Director: Benson Dutton
Division of Reimbursement and Economic Studies

Description: Each year the Health Care Financing Administration (HCFA) publishes the Medicare Economic Index (MEI) (congressionally mandated by Public Law 92-603) for use in limiting growth in prevailing charges for physician services. The MEI is developed by HCFA's Office of the Actuary mainly from selected components of the Consumers Price Index or the Producers Price Index, plus a malpractice component. HCFA's Office of Research and Demonstrations develops the data to calculate the malpractice component. Data for calculating the malpractice component of the Medicare Economic Index are obtained annually from major medical malpractice insurers. The medical malpractice component is an estimate of the annual changes in medical malpractice insurance premiums charged for a specific level of coverage.

Status: The requisite data have been obtained so that results could be provided to HCFA's Office of the Actuary. Announcement of the MEI was made in the Federal Register, September 30, 1985.

Analysis of Physician Fee Information from Several Sources

Funding: Intramural
Project Director: Benson Dutton
Division of Reimbursement and Economics Studies

Description: Physician fees for selected procedures will be examined from three data sources: the physician-oriented data base (PODB) developed by Mandex, Inc., under Contract HCFA 500-83-0046; the National Opinion Research Center Survey of Physicians' Practice Costs and Income Survey (PPCIS) under HCFA Contract No. 500-83-0025; and the Medicaid Tape-to-Tape data base developed by Systemetrics, Inc., under HCFA Contract No. 500-84-0037. The PODB originates from Medicare paid claims, the PPCIS fee data is self-reported by physicians, and Tape-to-Tape fee data originates in Medicaid paid claims. The aggregation of data from these sources is exploratory.

Status: The Medicare PODB data have been extracted. Data processing requests have been issued for extracts of the Medicaid Tape-to-Tape and the PPCI Survey data. A staff note will be prepared.

Assignment Rates Revisited

Funding: Intramural
Project: Alma McMillian
Director: Division of Beneficiary Studies

Description: The level of the assignment rate for physicians' services is of continuing interest. Beneficiaries are affected financially when the physician elects not to accept payment for services on an assigned basis. Data on physician assignment rates through 1978 have been published earlier. This study looks at the overall trend in assignment rates through September 1985 and compares changes in assignment rates for 1975 and 1982, by age, sex, race, and State. Assignment rates by physician specialty are also analyzed, as well as the effect of mandatory assignment, i.e., automatic assignment of charges for Medicaid eligibles.

Status: The study shows that substantial increases in the assignment rate have coincided with the implementation of provisions in the Deficit Reduction Act of 1984 to encourage assignment, and the assignment rate reached an all-time high of 69 percent in the first 9 months of 1985. The study also shows that in 1982 about 52 percent of the $17.6 billion in physicians' charges to aged Medicare beneficiaries was assigned; about 70 percent of the $2.2 billion in charges to disabled beneficiaries was assigned. These figures represent an increase from the rate of 47 percent for the aged in 1975 and an increase from the rate of 64 percent for disabled in 1976. The exclusion of charges for Medicaid eligibles, which are automatically assigned, reduces the assignment rate several percentage points. For aged enrollees, the rate dropped 6 percentage points to 46 percent. The effect of unassigned claims on beneficiary liability was also examined. Inflation-adjusted liability per aged user increased 64 percent from 1975 to 1982 (from $42 to $69). The most important factor behind this increase was the 61-percent increase in inflation-adjusted physician charges during this period. One-fourth of aged users had a liability of $100 or more in 1982, and more than one-fifth of disabled users had that much liability. An article on this study, "Trends in physician assignment rates for Medicare services, 1968-84," will be published in the Winter 1985 issue of the Health Care Financing Review.

Other Physician Payment

Physician Reimbursement and Continuing Care under Medicaid in Suffolk County, New York

Project No.:	11-C-98052/2-04
Period:	September 1981 - December 1986
Funding:	$ 643,952
Award:	Cooperative Agreement
Awardee:	New York Department of Social Services Division of Medical Assistance 40 North Pearl Street Albany, N.Y. 12243
Project Officer:	Andrew K. Solarz Division of Health Systems and Special Studies

Description: This demonstration is designed to test the impact of alternative methods of physician reimbursement on the provision of continuing care for Medicaid children in Suffolk County, N.Y. The methods include the current fee schedule, a fee-for-service/continuing care method that reimburses physicians at a higher rate for accepting continuing comprehensive care, and a comprehensive prepayment plan.

Status: The project began the operational phase in July 1983. Major milestones include development of capitation rates and an augmented fee schedule; development of claim payment, data collection, and management reporting systems; and enrollment of physicians and recipients. Active enrollment of children and physicians ended May 1, 1984. As of August 1985, 3,400 children and 72 physicians were participating in the demonstration. Services to children will continue through 1985. The project will be phased out during the first half of 1986 and the evaluation will be completed by December 1986.

Impact of Physician Supply and Regulation on Physician Fees and Utilization of Services

Project No.:	18-P-97619/5
Period:	March 1980 - December 1985
Funding:	$ 408,287
Award:	Grant
Grantee:	Blue Cross/Blue Shield of Michigan 20800 Greenfield Oak Park, Mich. 48237
Project Officer:	Benson Dutton Division of Reimbursement and Economic Studies

Description: Blue Cross and Blue Shield of Michigan (BCBSM) has used paid claims files to examine the issue of physician-induced demand. BCBSM has also examined market areas in Michigan with private and Medicare-paid claims from 1975 to 1980. In addition, the study is investigating the impact of physician supply and regulation on the price and quantity of physician services. To supplement the paid-claims data, BCBSM has surveyed a sample of Michigan physicians to determine amenities, workload/hours, non-Blue Shield volume, and charges. This project will describe and analyze variation in per capita use across market areas. BCBSM is using patient illness diagnostic tracers from physician billing data. The inducement hypothesis is to be tested using a "Reinhardt test" of physicians' fees while holding relevant supply, demand, and amenities variables constant.

Status: The study identified 15 market areas in Michigan and showed that there were major differences between market areas in use rates as well as the growth in those rates. The areas with the highest use rates in 1975 were also the markets with the highest growth in use. On induced demand, the data support the hypothesis that an increase in the availability of doctors increases the use of services, but the evidence refutes the target-income hypothesis by showing that fees move toward competitive levels. BCBSM interim reports were very useful in resolving the clinic locality issue in Michigan raised by Congressman Robert Davis (R-MI) in 1982. Other reports received include:

- "Medicare Assignment Rates in Michigan."
- "The Effects of Physician Availability on Fees and the Demand for Doctors' Services."
- "Survey of Michigan Physicians' Practice Characteristics."
- "Medicare Fees, Use, and Assignment Rates in Michigan's Physician Service Markets."
- "Fees or Use? What's Responsible for Rising Health Care Costs?"
- "The Determination of Medicare Market Areas and Medicare Fees, and Use in Michigan."

The final report will be available from the National Technical Information Service in early 1986.

STATE PROGRAMS FOR LONG-TERM CARE

Channeling

Evaluation of Coordinated Community-Oriented, Long-Term Care Demonstration

Project No.:	500-80-0073
Period:	September 1980 - September 1984
Funding:	$ 2,913,823
Award:	Contract
Contractor:	Berkeley Planning Associates 3200 Adeline Street Berkeley, Calif. 94703
Project Officer:	Kathy Ellingson Division of Long-Term Care Experimentation

Description: This long-term care project evaluates a series of demonstration projects which tested the delivery of coordinated community care services. Specifically, the demonstrations tested whether care tailored to clients' needs could keep them in the community instead of moving them into expensive institutional care settings.

Status: The contractor completed case studies for the participating projects that highlight the history and origin of the project, describe project organization, and discuss operational issues. A final report focusing on quality-of-care and cost-effectiveness issues is being reviewed for release in early 1986. One of the projects under review by Berkeley Planning Associates, the Assessment for Community Care Services (ACCESS) Medicare program, did not become operational until November 1982 and will serve clients until July 1986. This evaluation is in progress and is the final segment of the project. Results from the ACCESS Medicare evaluation will be available in late 1986.

National Long-Term Care Channeling Demonstrations

Period: September 1980 - May 1985

Description: This is a major national research and demonstration program. It is a combined effort of three components in the Department of Health and Human Services: the Health Care Financing Administration (HCFA); the Office of the Assistant Secretary for Planning and Evaluation, Office of the Secretary; and the Administration on Aging, Office of Human Development Services. The program has been testing whether and to what extent the long-term care needs of elderly impaired persons can be met in a cost-effective way through a community-based system of comprehensive needs assessment, care planning, and case management. These components are the core channeling services. Five of the projects were designated as "complex-model projects." These projects alter the basic channeling model by adding three program elements under HCFA waivers: expanded Medicare and Medicaid service coverage, authorization to approve reimbursement for services, and limitations on per capita expenditures. The projects completed the demonstration phase-down activities in March 1985. Final activities are currently under way.

Project Nos.:	11-P-98211/4-02 HHS-100-80-0136
Funding:	$ 932,896
Contractor/ Grantee:	Florida Department of Health and Rehabilitative Services 1317 Winewood Boulevard Tallahassee, Fla. 32301
Project Officer:	William Saunders Division of Long-Term Care Experimentation

Status: The Miami Jewish Home and Hospital for the Aged was designated as the organization responsible for implementing the Florida project. This site was selected as a complex-model project. The project catchment area included the city of Miami and several surrounding communities. The project began serving clients in May 1982, and reached an active caseload of 450 clients. The State continued the project as an ongoing State-funded program after demonstration services ended in March 1985.

Project No.:	HHS-100-80-0138
Funding:	$ 700,000
Contractor:	Kentucky Cabinet for Human Resources 275 East Main Street Frankfort, Ky. 40621
Project Officer:	William Saunders Division of Long-Term Care Experimentation

Status: The Kentucky Department for Social Services was designated as the agency responsible for implementing the Kentucky project. This site was selected as a basic-model project. The project catchment area covered eight rural counties in eastern Kentucky. The project began serving clients in February 1982, and reached a caseload of 250 clients. The State continued the project as an ongoing, State-funded program after demonstration services ended in March 1985.

Project No.: HHS-100-80-0139
Funding: $ 609,839
Contractor: Maine Department of Human Services
State House, Station II
Augusta, Maine 04333
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Maine demonstration site was a basic-model project administered under a subcontract with Southern Maine Senior Citizens, Inc., an Area Agency on Aging in Portland. The two-county catchment area, Cumberland and York Counties, covered 2,000 square miles. The project began serving clients in February 1982, and reached an active caseload of 216 clients by the end of July 1983. After the demonstration ended in March 1985, the project received funding support from the State and sponsoring area agency which allowed the agency to continue serving clients with case-management services and expanded community-based services.

Project Nos.: 11-P-98210/1-02
HHS-100-80-0141
Funding: $ 1,657,617
Contractor/ Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Status: The Massachusetts channeling demonstration was a complex-model site operated by Greater Lynn Senior Services. The catchment area included Greater Lynn and the Beverly area. The project began serving clients in May 1982. The project reached its target caseload of 300 clients by the end of July 1983. Even though the demonstration ended in March 1985, the contractor is continuing to serve the remaining clients through a combination of Medicaid funds and State contributions.

Project No.: 11-P-98213/2-02
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: Thomas M. Kickham
Division of Long-Term Care Experimentation

Status: The Rensselaer County Department for the Aging was designated as the agency responsible for implementing the New York project. This site was selected as a complex-model project. The project catchment area was Rensselaer County, N. Y. The project began serving clients in May 1982 and completed an orderly wind-down on March 31, 1985. Clients were transferred to existing long-term care resources in the community.

Project No.:	11-P-98209/5-02
Grantee:	Ohio Department of Public Welfare 30 East Broad Street Columbus, Ohio 43215
Project Officer:	Thomas M. Kickham Division of Long-Term Care Experimentation

Status: The Cuyahoga County Board of Commissioners was designated as the agency responsible for implementing the Ohio project. The project site is administered by the Western Reserve Area Agency on Aging. The project catchment area covered Cuyahoga County, which consists of the city of Cleveland and surrounding suburbs. The project began serving clients in May 1982 and an orderly transition of phase-down activities were completed in March 1985. Using a combination of funding sources, the State continues to provide channeling services to the remaining participants.

Project Nos.:	11-P-98212/3-02 HHS-100-80-0146
Funding:	$ 2,235,982
Contractor/ Grantee:	Pennsylvania Department of Public Welfare Health and Welfare Building Harrisburg, Pa. 17120
Project Officer:	Leslie Saber Division of Long-Term Care Experimentation

Status: The Pennsylvania channeling project was operated through a subcontract with the Philadelphia Corporation for Aging. This site was a fully centralized complex model project site. The catchment area covered more than 129 square miles and included the city and county of Philadelphia. The project began serving clients in May 1982. By the middle of June 1983, the project reached its target caseload of 500 clients. A final transition/termination plan was submitted at the beginning of June 1984. Currently, the State is continuing to serve clients under a State-funded preadmission screening and case-management program.

Community-Based Care

Demonstration of Community-Wide, Alternative Long-Term Care Model

Project No.: 11-P-90130/2-10
Period: July 1976 - July 1986
Funding: $ 960,938
Award: Grant
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The New York State Department of Social Services is demonstrating alternative approaches to delivering and financing long-term care to the adult disabled and elderly Medicaid population of Monroe County, N.Y. The project has developed the Assessment for Community Care Services (ACCESS) model as a centralized unit responsible for all aspects of long-term care for Monroe County residents 18 years of age or over who are eligible for Medicaid and have long-term health care needs. ACCESS staff provide each client with comprehensive needs-assessment and case-management services.

Status: The project received waivers to permit provision of certain community long-term care services not normally provided under Medicaid in New York. Since the project became operational in 1977, more than 23,000 people with potential long-term care needs have received assessments under this program. The demonstration will begin phase down in January 1986, and will be completed in July 1986.

Continued Demonstration of a Long-Term Care Center Through Inclusion and Expansion of Title XVIII

Project No.: 95-C-97254/2-05
Period: August 1980 - July 1986
Funding: $ 2,645,603
Award: Cooperative Agreement
Awardee: Monroe County Long-Term Care Program, Inc.
55 Troup Street
Rochester, N.Y. 14608
Project Officer: William Saunders
Division of Long-Term Care Experimentation

Description: The purpose of this demonstration is to expand the alternative long-term care delivery model Assessment for Community Care Services (ACCESS) developed for the Medicaid population in Monroe County, N. Y., to include the county's Medicare population. The addition of this Medicare project is for the purpose of working toward an integration of Medicare and Medicaid long-term care services.

Status: The project began operations in October 1982. The Health Care Financing Administration has contracted with New York Blue Cross to serve as Medicare fiscal intermediary for the demonstration. Thus far, more than 10,000 Medicare beneficiaries with potential long-term care needs have received assessments from the project. The project will begin phase down in January 1986, and will be completed in July 1986.

Home Services for Functionally Disabled Adults

Project No.: 18-P-97462/2-03
Period: June 1980 - July 1985
Funding: $ 488,075
Award: Grant
Grantee: Community Service Society
Institute for Social Welfare Research
105 East 22nd Street
New York, N.Y. 10010
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: Close to 1,000 functionally disabled, low-income adults in New York City were followed for 12-months after acute hospitalization to determine the impact of ongoing home-service programs. Access to services, quality of services delivered, participation of informal supports, quality of circumstances, durability of independent living arrangements, and public costs were examined. Data for this project included survey data and Medicare and Medicaid expenditure data.

Status: The final report for this project was received in July 1985. The principal findings were:

- Nearly half of the most disabled study subjects who were living alone did not have formal home services in place at hospital discharge. The report recommends stronger discharge planning in hospitals.

- Functional disability had implications for frequency of help and source of help. The more disabled received more frequent help than did the less disabled. At low and moderate disability levels, informal supports were the more frequent source of help. Among the highly functionally disabled, the most common pattern was a mix of help from formal and informal sources.

- A linear relationship between functional disability and help from informal supports was found; that is, the extent of help provided by informal supports tended to increase in proportion to increases in functional disability.

- The relationship between the activity of daily living measure of functional disability and help provided by organized services was nonlinear; at higher disability levels, the extent of help from organized services tended to level off.

- Subjects tended to report high levels of satisfaction with organized services.

- Three specific areas were identified in which home care improvements are needed: the functionally disabled elderly tend to need more help in traveling short distances; informal supports (notably daughters and spouses) who live with care recipients and provide extensive help tend to need improved respite services; and stronger efforts are needed to make organized home care available to Hispanics at home.

South Carolina Community Long-Term Care Project

Project No.: 99-P-97493/4-04
Period: September 1979 - December 1984
Award: Grant
Grantee: South Carolina Department of Social Services
P.O. Box 1520
Columbia, S.C. 29202-9988
Project Officer: Leslie Saber
Division of Long-Term Care Experimentation

Description: Through Medicaid and Medicare waivers, the State conducted a demonstration in three counties which tested community-based client assessment, coordination of services, and provision of alternative services. It was hypothesized that the waivers would increase the use of home care services, thereby reducing reliance on hospitals and lowering the incidence of conversion from Medicare to Medicaid in nursing homes.

Status: The demonstration ended in December 1984, and all appropriate clients are receiving services through the statewide system that was implemented under the authority of Section 2176 waivers. The grantee submitted a draft final report in August 1985, which is currently under review.

Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged

Project No.: 11-P-97473/6-06
Period: January 1980 - December 1985
Award: Grant
Grantee: Texas Department of Human Resources
706 Banister Lane
Austin, Tex. 78769
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: The purpose of this project is to reduce the growth of nursing homes in Texas and, at the same time, expand access to community care services for needy Medicaid individuals. It is being accomplished by directly changing the operating policies of the State's Title XIX and XX programs; in particular, by eliminating the State's lowest level of institutional care--intermediate care facility (ICF) II. Existing organizations responsible for the State's Title XIX and XX programs are responsible for project implementation.

Status: The project is in its sixth and final year. In March 1980, there were 15,486 individuals in the ICF-II group. As of March 1985, there were 3,985 clients remaining. In addition, 2,246 more clients were receiving primary home care services in the community. From March 1980 to March 1985, the total nursing home population decreased from 64,643 clients to 54,424 clients. Phase-out procedures have begun. A final report is expected by Spring 1986.

Systematic Examination of Factors that Promote Home Care by the Family

Project No.: 18-C-98385/5-03
Period: September 1983 - December 1986
Funding: $ 401,529
Award: Cooperative Agreement
Awardee: Abbott Northwestern Hospital, Inc.
Planning and Marketing Department
800 East 28th Street at Chicago Avenue
Minneapolis, Minn. 55407
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: The primary purpose of this project is to describe the role of urban and rural family members in providing home care to frail and chronically ill relatives. It will assess the impact that formal support systems, such as health and social services, have on the promotion of home care. Detailed data is being collected on the caregiving experiences of families of persons meeting the study criteria of advanced age, impairment, living in a private home, and family contacts.

Status: Data from the rural families have been collected. The urban families are currently being interviewed. Details are being finalized for a nursing home substudy of 150 hospital patients who are discharged to nursing homes (and their caregivers). Preliminary data analysis will begin in November 1985.

Assess (State) Tax Incentives as a Means of Strengthening the Informal Support System for the Elderly

Project No.: 99-C-98410/9-03
Period: September 1983 - September 1986
Funding: $ 387,454
Award: Cooperative Agreement
Awardee: Center for Health and Social Services Research
155 South El Molino
Pasadena, Calif. 91101
Project Officer: Sherry A. Terrell
Division of Reimbursement and Economic Studies

Description: The purpose of this project is to study selected State (Arizona, Idaho, Iowa, and Oregon) tax incentives that are believed to stimulate the informal caregiver system and reduce either current or anticipated demands on the formal long-term care system. Specific objectives are:

- To describe and analyze tax incentives that have been implemented in selected States.
- To develop a predictive model to identify those persons in the general elderly population and their informal caregivers who are likely to take advantage of tax incentives.
- To determine the potential impact of the tax incentive programs in preventing or delaying institutionalization.

Status: The project is in its third and final year. State Tax Commissioners and their departments have accepted major roles in the study. Favorable study circumstances were found in Idaho where, in 1982, more than 700 individuals claimed deductions or credits. The Idaho tax incentive program cost the State an estimated $65,900 in lost revenue or about $93.00 per claimant. From preliminary examination of Idaho data, the elderly dependent is characterized as being the widowed mother or mother-in-law of the claimant. She is over 80 years of age, has one or more chronic health conditions, and would likely be dependent on public assistance if the informal support system was disrupted. Claimants are generally married with beginning health problems of their own, somewhat older than the average Idaho population, and nearing retirement age. Data collection began in Arizona in the second year of the project and will be completed by early Spring 1986. Data analysis has begun and a final report is expected by the end of 1986.

Respite Care Co-Op for Impaired Elderly

Project No: 18-C-98398/5-03
Period: September 1983 - September 1986
Funding: $ 128,880
Award: Cooperative Agreement
Awardee: Southcentral Michigan Commission on Aging
2401 East Milham Road
Kalamazoo, Mich. 49002
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This feasibility study has developed a model cooperative to provide respite for family caregivers of impaired elderly. Family members pay for care received with care given. The objectives are to study the feasibility and cost of establishing a model cooperative designed to prevent exhaustion of family members, to eliminate the need for more intensive and/or expensive care, and to prevent unnecessary institutionalization of the elderly.

Status: The policy and procedure manuals were developed by an advisory group composed of future caregivers, the program coordinator, and consultants with previous experience in a similar setting. Issues such as caregiver training, care receiver characteristics (such as mobility, orientation/disorientation, etc.), legal implications of providing care, and insurance coverage were thoroughly investigated. One co-op has been established with eight families participating. Four major workshops have been held to interest other agencies in developing co-ops. A constant informative media campaign attempts to reach those who would be appropriate members. An outside evaluation is addressing issues relating to the development and implementation of this model, as well as those regarding its outcomes.

On Lok's At-Risk, Capitated Payment Demonstration

Project Nos.: 95-P-98246/9-02
11-P-98334/9-02
Period: November 1983 - November 1986
Award: Grant
Grantees: On Lok Senior Health Services
1441 Powell Street
San Francisco, Calif. 94133
and
California Department of Health Services
714-744 P Street
Sacramento, Calif. 95814
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: In response to the congressional mandate of Section 603(c)(1) and (2) of the Social Security Amendments of 1983, the Health Care Financing Administration granted Medicare waivers to the On Lok Senior Health Services and Medicaid waivers to the California Department of Health Services. Together these waivers permit On Lok to implement an at-risk, capitated payment demonstration in which 300 frail elderly persons, at risk of institutionalization, are provided a comprehensive array of health and health-related services.

Status: During the course of the demonstration, On Lok is reimbursed for the services provided based on a prospective capitated rate from both Medicare and Medi-Cal (Medicaid). The Medicare rate is based on the adjusted average per capita cost (AAPCC) for Medicare's institutionalized population and the Medi-Cal rate is based on California's computation of the average cost for similar recipients. A copayment system has been developed for those who are eligible for Medicare only. The research staff continues to carry out a variety of analytical studies based on participant-related data. In addition, a comparison group study is in progress.

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Incentive Reimbursement Plan for Medicaid Home Health Services

Project No.: 11-C-98549/1-01
Period: December 1984 - November 1986
Funding: $ 162,452
Award: Cooperative Agreement
Awardee: State of Connecticut
Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Conn. 06106
Project Officer: Michael J. Baier
Division of Long-Term Care Experimentation

Description: This 2-year project proposes to reward Medicaid clients for using lower cost home health agency services through the payment of rebates. The overall purpose is to test whether the granting of rebates will result in more cost-effective use of home health services. The project will include 1,200 Medicaid clients in Hartford, Conn., who are in need of home health care. The project will also measure the impact on patient functional status, health, and client satisfaction.

Status: The project was awarded in November 1984, for the first of 2 project years. The first-year period began December 1, 1984, and extends through November 30, 1985. However, a 6-month extension through May 31, 1986, is planned. Staff have been hired and the details of a 90-day pilot project, which will be conducted prior to the full-scale demonstration, are being finalized.

Deinstitutionalization of the Chronically Mentally Ill

Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: This project is a joint effort between the Departments of Housing and Urban Development (HUD) and Health and Human Services under the Demonstration for Deinstitutionalization of the Chronically Mentally Ill. HUD provided loans for the construction of community-based housing under Section 202, and rental assistance under Section 8. The Health Care Financing Administration is providing Medicaid waivers to permit reimbursement for a 3-year period for services such as case management, life skills training, supervision, and transportation.

Status: Section 1115 waivers were approved for 43 HUD-approved sites in 12 States. Three States (Connecticut, Minnesota, and Tennessee) have completed the 3-year waiver coverage, and payment for the services is now made entirely from State funds.

A Model Addressing the Residential Needs of the Chronically Mentally Ill

Project No.: 11-P-98117/6-04
Period: July 1982 - May 1987
Award: Grant
Grantee: Arkansas Department of Human Services
Seventh and Main Streets
Little Rock, Ark. 72201

Effective and Efficient Community Support Services for the Chronically Mentally Ill

Project No.: 11-P-98000/3-05
Period: September 1981 - December 1986
Award: Grant
Grantee: Office of Health Care Financing
1331 H Street N.W., Fifth Floor
Washington, D.C. 20005

Cost-Effective Community Alternatives to Institutionalization of the Chronically Mentally Ill

Project No.: 11-P-97575/4-05
Period: April 1981 - March 1986
Award: Grant
Grantee: Georgia Department of Medical Assistance
Suite 1266, West Tower
2 Martin Luther King Drive
Atlanta, Ga. 30334

Cost-Effective Comprehensive Community Residential Treatment of the Chronically Mentally Ill

Project No.: 11-P-98242/1-04
Period: November 1982 - May 1987
Award: Grant
Grantee: Maine Department of Human Services
221 State Street
Augusta, Maine 04333

Housing and Urban Development Demonstration Program for the Chronically Mentally Ill

Project No.: 11-P-97563/5-05
Period: May 1980 - September 1985
Award: Grant
Grantee: Minnesota Department of Human Services
658 Cedar Street
St. Paul, Minn. 55155

Cost-Effective Community Alternatives to Deinstitutionalization of the Chronically Mentally Ill

Project No.: 11-P-98100/1-04
Period: November 1982 - June 1987
Award: Grant
Grantee: New Hampshire Division of Welfare
Hazen Drive
Concord, N.H. 03301

Services in Housing and Urban Development Transitional Housing for Chronically Mentally Ill

Project No.: 11-P-97799/2-04
Period: August 1982 - July 1986
Award: Grant
Grantee: New Jersey Department of Human Services
Division of Medical Assistance
222 South Warren Street
Trenton, N.J. 08625

Deinstitutionalization of the Chronically Mentally Disabled, Cost-Effective Community Alternatives

Project No.: 11-P-98118/1-04
Period: June 1982 - May 1987
Award: Grant
Grantee: Department of Social and Rehabilitative Services
600 New London Avenue
Cranston, R.I. 02920

Housing and Urban Development Demonstration Program for the Chronically Mentally Ill

Project No.: 11-P-97952/4-04
Period: May 1981 - May 1985
Award: Grant
Grantee: Tennessee Department of Public Health
Bureau of Medicaid Administration and Coordination
283 Plus Park Boulevard
Nashville, Tenn. 37217

Community Alternatives to the Institutionalization of the Chronically Mentally Ill

Project No.: 11-P-98259/1-02
Period: March 1983 - September 1985
Award: Grant
Grantee: Connecticut Department of Income Maintenance
110 Bartholomew Avenue
Hartford, Conn. 06115

Cost-Effective Community Residential Treatment for the Mentally Ill

Project No.: 11-P-97787/1-05
Period: August 1981 - November 1986
Award: Grant
Grantee: Vermont Agency of Human Services
Department of Social Welfare
103 South Main Street
Waterbury, Vt. 05676

Highline Independent Apartment Living Project

Project No.: 11-P-98200/0-04
Period: April 1982 - April 1986
Award: Grant
Grantee: Department of Social and Health Services
Division of Medical Assistance, LK-11
Olympia, Wash. 98504

Quality

Improving New York State's Nursing Home Quality Assurance Program

Project No.:	11-P-97590/2-05
Period:	September 1980 - March 1986
Award:	Grant
Grantee:	State of New York Department of Social Services Tower Building Empire State Plaza Albany, N.Y. 12237
Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: This project tests the simplification of federally mandated periodic medical review/independent professional review processes in nursing homes, and combines the process with the annual facility survey. Surveyors use 11 sentinel health events (SHE), such as accidents, decubitus ulcers, and medication regimen to determine if nursing home patients are receiving quality care. Facilities found to have fewer than the average problems in these areas receive a less than full facility survey. This combined medical review and survey method reduces surveyors' time and allows State personnel to focus on facilities and patients with major problems.

Status: The project is currently in its fifth and final year. The new inspection of care processes are fully operational. The State indicates that the new system provides documentation to allow them to take positive corrective actions against nursing homes found to be in noncompliance. The final report and evaluation of the fourth and fifth years will be submitted in Summer 1986.

Quality Assurance Sampling: A Statistical Quality-Control Approach to Inspection of Care

Project No:	11-C-98260/1-03
Period:	February 1983 - February 1986
Funding:	$ 15,600
Award:	Cooperative Agreement
Awardee:	Massachusetts Department of Public Welfare 600 Washington Street Boston, Mass. 02111
Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: The main objective of the project is to verify that patients in nursing homes are receiving appropriate care at the appropriate level, without reviewing every patient. Current law requires a review of all Medicaid patients in a facility to verify the appropriateness of care and placement. This project will use statistical quality control techniques to achieve these goals so that surveyor time can be reallocated to other quality-assurance activities.

Status: Criteria have been developed for determining which facilities are appropriate for the sampling process. The procedures for sampling patients, including safeguards to control statistical biases, have been refined. Pretests of the process and orientation sessions for surveyors were conducted in July and August 1983. The project became operational on August 29, 1983. During the first quarter, more than 50 percent of the facilities received a 100-percent review based on the walk-through findings. During the last quarter of the first year and the first two quarters of the second year, only 25 percent of facilities have received a full review. This change is probably because of the learning process required to gain familiarity with the new procedures. During the second year of operation, the State developed a detailed evaluation plan for the project and is now hiring staff to carry out the evaluation analysis. The State has met with the Regional Office to begin planning for the return to full review in May 1986.

Evaluation of Three-State Demonstration in Nursing Home Quality Assurance

Project No.: 500-82-0024
Period: August 1982 - September 1984
Funding: $ 662,113
Award: Contract
Contractor: Mathematics Policy Research
905 University Avenue
Room 203
Madison, Wis. 53715
Project Officer: Spike Duzor
Division of Health Systems and Special Studies

Description: This is an evaluation of a three-State demonstration testing new procedures for conducting nursing home facility surveys and patient quality-of-care determinations. The States participating in this demonstration include Wisconsin, New York, and Massachusetts. The Wisconsin inspection of care and survey demonstration was completed in September 1982. The Massachusetts survey-by-exception project was completed in December 1982. The New York demonstration is still active.

Status: A draft final report is currently being reviewed by Health Care Financing Administration staff. The final report is expected in Winter 1986.

A Longitudinal Study of Case-Mix Outcomes and Resource Use in Nursing Homes

Project No.:	18-P-98717/1-01
Period:	September 1985 - August 1988
Funding:	$ 677,170
Award:	Grant
Grantee:	Brown University Box G Providence, R.I. 02912
Project Officer:	Elizabeth S. Cornelius Division of Long-Term Care Experimentation

Description: This study of natural histories of patient outcomes for subgroups of nursing home residents is a 3-year research project that will parallel the development of case-mix reimbursement. The objectives are:

- To create a typology that classifies residents into subgroups based on characteristics at admission.
- To measure patterns of outcomes for subgroups.
- To formulate appropriate use patterns for case-mix categories that are based on outcomes patterns.
- To provide a quality of care link between case mix and costs.
- To develop a basis for an outcome-oriented quality control system compatible with many reimbursement systems.

Two large files of longitudinal data on skilled nursing facility and intermediate care facility residents will be used. One data base has resident data from facilities in 11 States, the other one includes 350 facilities in 37 States. In addition, three crosscutting files with staff time information as well as resident characteristics, and two longitudinal files covering 2 years of data for Medicaid patients in two States will be used. The project will have four overlapping phases over 3 years. The first includes obtaining and preparing the data from various data sources for analyses. The second involves basic descriptive analyses including the development and validation of a clinically meaningful, outcome-oriented, case-mix classification for different subgroups. The third involves multivariate and facility-level analyses to assess the stability of the models and the sensitivity of results to variation in patient group composition, staffing, facility ownership, and/or State regulatory system. The fourth phase involves report preparation and dissemination of the results regarding natural histories of outcome for different subgroups of the nursing home population.

Status: The project began in September 1985. The research design has been finalized and includes identification of the data bases and samples that will be used for various parts of the study.

Planning Study: Phase I of a Major Study of National Long-Term Care Policies

Project No.:	**ASU000001-03**
Period:	**February 1985 - November 1985**
Funding:	**$ 150,000**
Award:	**Interagency Agreement**
Agency:	**National Academy of Sciences, Institute of Medicine** **2101 Constitution Ave** **Washington, D.C. 20418**
Project Officer:	**Judith Sangl** **Division of Reimbursement and Economic Studies**

Description: **The objectives of the planning effort are:**

- **To identify and define the major policy issues in long-term care that should be examined and assign priorities to them.**
- **To inventory available information on activities completed and under way with respect to data compilation, research, and policy analysis for evaluation during the course of the study.**
- **To design the study.**

The major study will be designed to facilitate development of a coherent set of public policies for providing and financing cost-effective, long-term care services that will adequately meet the national requirement for such services.

Status: **The planning study report is expected in Spring 1986.**

Evaluation of Massachusetts Case-Managed Medical Care for Nursing Home Patients

Project No.: 15-C-98489/9-02
Period: April 1985 - March 1988
Funding: $ 300,000
Award: Cooperative Agreement
Awardee: The Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: Tony Hausner
Division of Long-Term Care Experimentation

Description: The Health Care Financing Administration granted Medicare and Medicaid waivers to the Massachusetts Department of Public Welfare to permit fee-for-service reimbursement for the provision of medical services by physician-supervised nurse practitioners/physician assistants for 6,500 residents of nursing homes. This will permit increased medical monitoring that is expected to generate cost savings as a result of fewer hospital admissions and hospital outpatient visits. This evaluation will focus on the impact of the project on the use of nursing home services and hospital emergency room and outpatient services.

Status: Rand is currently making arrangements for the collection of Medicare and Medicaid claims data and is preparing the research plan.

Data Development and Analyses

Analysis of the 1982 Long-Term Care Survey

Funding:	Intramural
Project Director:	Candace Macken Division of Program Studies

Description: The 1982 Long-Term Care Survey (LTCS) was designed to provide nationally representative data on the number and degree of physical impairments found among Medicare beneficiaries 65 years of age or over living in the community. Approximately 35,000 persons were first screened over the telephone to determine whether any of them had problems performing any of a series of activities of daily living (ADL's) or instrumental activities of daily living (IADL's) for a period of at least 3 months. Persons living in institutions were excluded from the survey. Those who were determined to have limitations were then interviewed by personal visit and by a detailed questionnaire. Information was gathered on health conditions, ADL's, IADL's, helpers, cognitive functioning, social functioning, Medicare providers, health insurance, and income and assets.

Status: The Bureau of the Census completed data collection in October 1982. The analysis of the data and the development of reports are currently being carried out by researchers in the Health Care Financing Administration and the Office of the Assistant Secretary for Planning and Evaluation. These papers have been presented:

- "1982 Long-Term Care Survey: National Estimates of Functional Impairments Among the Elderly Living in the Community," presented at the National Association of Welfare Research and Statistics Conference in Hartford, Conn., August 1984.

- "1982 Long-Term Care Survey: Functional Impairments and Sources of Support of Elderly Medicare Beneficiaries Living in the Community," presented at the Gerontological Society of America Conference in San Antonio, Tex., November 1984.

Another paper that has been developed from this project is "A Profile of Functionally Impaired Aged Medicare Beneficiaries in the Community." This paper is scheduled for publication in the Summer 1986 issue of the Health Care Financing Review.

Analysis of the 1982 Survey of Informal Caregivers

Funding: Intramural
Project Director: Judith Sangl
Division of Reimbursement and Economic Studies

Description: The 1982 Survey of Informal Caregivers was designed to provide, on a national basis, a comprehensive picture of the informal system for long-term care. A supplement to the 1982 Long-Term Care Survey, the Caregiver Survey collected data on the kind, amount, and cost of informal care for a sample of 1,925 informal caregivers. Informal caregivers are defined as persons providing unpaid care and support to chronically impaired, noninstitutionalized elderly.

Status: The Health Care Financing Administration is collaborating in this analysis with the National Center for Health Services Research. Preliminary analyses and caregiver burden scaling has begun. A descriptive report is expected in early 1986.

The 1984 Long-Term Care Survey

Project No.: IAA-84-P-383
Period: October 1983 - December 1985
Funding: $ 1.9 million
Award: Interagency Agreement
Agency: The Bureau of the Census
Demographic Surveys Division
Suitland, Md. 20233
Project Officer: Candace Macken
Division of Program Studies

Description: The 1984 Long-Term Care Survey (LTCS) capitalizes on the data collected for the 1982 Survey by interviewing the same persons, thus providing a longitudinal look at the functionally impaired elderly living in the community. The 1982 Survey has been expanded to provide a cross-sectional look at all functionally impaired Medicare beneficiaries 65 years of age or over no matter where they reside. The longitudinal component comprises all persons included in 1982 and still living in the community and all persons included in 1982 and now living in institutions and those who are deceased. The cross-sectional component comprises the longitudinal component and persons who were excluded in 1982 because they were institutionalized, a sample of person who did not screen into the 1982 Survey because they were not functionally impaired, and persons who have aged into the sample, that is persons who were 63 and 64 years of age in 1982 and who were 65 and 66 years of age in 1984. Persons were interviewed personally by using a detailed community questionnaire similar to the one used in 1982. Interviews were with a proxy for those who were institutionalized or deceased by using abbreviated questionnaires that collect information on services used and source of payment. Data for 1984 will make possible the analysis of circumstances leading to institutionalization and whether alternatives could have been considered. This would identify methods of intervention to forestall premature or inappropriate nursing home placements and thus reduce current estimates of national expenditures for nursing home services, particularly for the Medicaid program.

Status: Data collection has been completed. The Bureau of the Census is in the process of constructing the data file. Use of the file for analyses is expected to begin in late 1986.

National and Cross-National Study of Long-Term Care Populations

Project No.: 18-C-98641/4-01
Period: September 1984 - September 1987
Funding: $ 396,078
Award: Cooperative Agreement
Awardee: Duke University
Center for Demographic Studies
2117 Campus Drive
Durham, N.C. 27706
Project Officer: Candace Macken
Division of Program Studies

Description: The objective of this study is to assess the size, characteristics, and future growth of the elderly long-term care (LTC) population in the United States by using data from the 1982 and 1984 Long-Term Care Surveys. Multivariate analyses will be used to develop profiles of attributes that characterize distinct subgroups in the noninstitutionalized LTC population and to target individuals at risk of institutionalization. Comparative analyses will be performed using similar surveys from other countries.

Status: Preliminary analyses of the 1982 Survey have been completed for a 50-percent sample, using a grade-of-membership (GOM) model. This GOM model developed profiles of disability, medical conditions, and LTC service needs and utilization levels for persons in the sample. Three articles have been published from the findings of this project:

- "Dynamics of Health Changes in Oldest Old: New Perspectives Versus Evidence," Milbank Memorial Fund Quarterly, Vol. 63, 1985.
- "Health Status and Service Needs of the Oldest Old: Current Patterns and Future Trends," Milbank Memorial Fund Quarterly, Vol. 63, 1985.
- "Home Care Expenses for Noninstitutionalized Elderly with ADL and IADL Limitations," Health Care Financing Review, Vol. 7, Winter 1985.

Long-Term Care Residential Services for Developmentally Disabled People

Project No.: 18-P-98078/5-03
Period: September 1981 - December 1985
Funding: $ 1,166,635
Award: Grant
Grantee: University of Minnesota
207 Pattee Hall
150 Pillsbury Drive, SE.
Minneapolis, Minn. 55455
Project Officer: Marni Hall
Division of Reimbursement and Economic Studies

Description: This project updated the only national information system on long-term care services for the mentally retarded and developmentally disabled (MR/DD). Data were gathered on characteristics of residents and facilities, including intermediate care facilities for the mentally retarded (ICF/MR's). Data from this study were used to track the effects of recent State deinstitutionalization policies. As part of the project, policy analyses of the cost/utilization of Medicaid MR/DD services were made. These analyses focused on: financing of residential care; case mix and movement of residents; and programs, services, and manpower.

Status: A draft final report has been received and is currently being revised. The final report is expected in Winter 1985. Major findings include the following:

- ICF/MR (both Federal and State) expenditures were the fastest growing component of both State residential care and Medicaid long-term care expenditures.
- Increases in ICF/MR expenditures prior to 1977 were primarily the result of increases in total recipients of care rather than increases in per recipient costs.
- Since 1977, increases in ICF/MR expenditures were primarily the result of increases in per recipient costs. About 70 percent of the increase in program costs from 1977 to 1982 can be attributed to increasing per diem costs.
- Between 1977 and 1982, the proportion of occupied MR/DD residential system beds that were certified for ICF/MR reimbursement grew from 43 percent to 58 percent of total beds.
- The fastest growing segment of the ICF/MR program was the small (15 or fewer residents) ICF/MR facilities. These facilities had a net increase of almost 500 percent (7,000 residents) between 1977 and 1982, and tend to be concentrated in a few States.
- Almost all growth in large (16 or more residents) facilities took place through certifying existing facilities for ICF/MR participation, while new small ICF/MR facility beds were generally in newly opened facilities.

- **The proportion of residents in large public institutions, whose care was paid for by the ICF/MR program rather than by State funding exclusively, substantially increased between 1977 and 1982.**

- **A shift from public to private providers is taking place within the ICF/MR program.**

- **States vary remarkably in the total size and characteristics of their ICF/MR programs, and in the proportion of their residential care systems certified for the ICF/MR program.**

- **Movement patterns of ICF/MR residents in fiscal year 1982 reflect a continuing trend toward less institutional models of care.**

- **The ICF/MR population is becoming more severely impaired.**

National Academy of Sciences Panel on Statistics for an Aging Population

Project No.: IAA-84-P432
Period: December 1984 - December 1986
Funding: $ 102,000
Award: Interagency Agreement
Agency: National Academy of Sciences
Committee on National Statistics
2101 Constitution Avenue
Washington, D.C. 20418
Project Officer: Judith A. Kasper
Division of Beneficiary Studies

Description: The purpose of this study is to examine the adequacy of current statistical information and methodology, particularly in the area of health and medical care, for an aging population. The study is being conducted through the Committee on National Statistics of the National Academy of Sciences/National Research Council, and is being supported by several Government agencies including the Health Care Financing Administration, National Institute of Mental Health, National Institute on Aging, National Center for Health Statistics, and Veterans' Administration. The study will determine:

- Whether the data that will be needed during the next decade for policy development for health care for an aging population are available.
- Whether available data are analyzed and used.
- Whether changes or refinements are needed in the statistical methodology used in both policy analysis and in the planning and administration of programs.

Status: A final report will be submitted to the sponsoring agencies at the end of the 2-year study in 1986.

AFDC Home Health Aides

AFDC Homemaker/Home Health Aide Demonstration

Period: January 1982 - September 1986
Project Officer: Dennis M. Nugent
Division of Long-Term Care Experimentation

Description: This demonstration was developed to study whether Aid to Families with Dependent Children (AFDC) recipients can be trained and employed to provide homemaker/home health aide services to elderly and disabled individuals who are at risk of institutionalization. The objectives of the demonstration are to reduce welfare dependency and to prevent or delay the institutional placement of functionally impaired service clients. After the AFDC recipients have successfully completed their formal training, they are employed as homemaker/home health aides by either a private nonprofit or public agency for 1 year. During this period, their employment is subsidized by demonstration funding. When this year ends, the State helps these aides find permanent jobs.

Status: During the past 3 years of the demonstration, more than 3,500 welfare recipients have been trained to provide homemaker/home health aide services to over 8,800 elderly and disabled clients. After a 6-month planning and development phase, the operational segment of the project was implemented in January 1983. At that time, the seven States participating in this demonstration began the process of recruiting and selecting eligible AFDC recipients. The project is now in its wind-down period. A final evaluation report is expected in July 1986.

A Plan for Employing AFDC Recipients as Homemaker/Home Health Aides to Provide Alternatives to Long-Term Care

Project No.: 12-P-98110/6-04
Award: Grant
Grantee: Arkansas Department of Human Services
Seventh and Main Streets
P.O. Box 1437
Little Rock, Ark. 72203

Preventacare: An Alternative to Institutionalization

Project No.: 12-P-98111/4-04
Award: Grant
Grantee: Kentucky Cabinet for Human Resources
CHR Building, Sixth Floor West
275 East Main Street
Frankfort, Ky. 40621

AFDC Homemaker/Home Health Aide Demonstration Project

Project No.: 12-P-98113/2-04
Award: Grant
Grantee: New Jersey Department of Human Services
Capitol Place One
222 South Warren Street
Trenton, N.J. 08625

New York State AFDC Homemaker/Home Health Aide Demonstration

Project No.: 12-P-98103/2-04
Award: Grant
Grantee: New York State Department of Social Services
40 North Pearl Street, 7th Floor
Albany, N.Y. 12243

Employment Opportunities for AFDC Recipients in the Homemaker/Home Health Aide Field

Project No.: 12-P-98106/5-04
Award: Grant
Grantee: Ohio Department of Human Services
30 East Broad Street, 27th Floor
Columbus, Ohio 43215

Homemaker/Home Health Aide Project

Project No.: 12-P-98108/4-04
Award: Grant
Grantee: South Carolina Department of Social Services
P.O. Box 1520
Columbia, S.C. 29202

AFDC Recipients as Providers of Services to the Aged and Disabled

Project No.: 12-P-98104/6-04
Award: Grant
Grantee: Texas Department of Human Services
522-A, P.O. Box 2960
Austin, Tex. 78769

Evaluation of the AFDC Homemaker/Home Health Aide Demonstration Project

Project No.:	**500-82-0022**
Period:	**June 1982 - June 1986**
Funding:	**$ 454,174**
Award:	**Contract**
Contractor:	**Abt Associates, Inc. 55 Wheeler Street Cambridge, Mass. 02138**
Project Officer:	**Kathy Ellingson Division of Long-Term Care Experimentation**

Description: The purpose of this project is to evaluate the Aid to Families with Dependent Children (AFDC) Homemaker/Home Health Aide demonstration and to provide technical assistance to the seven States participating in the demonstration. The actual evaluation will occur under separate contracts with the seven participating States. A final report to HCFA will be based on the State evaluations. The three major evaluation objectives are to:

- Assess the costs and effectiveness of the training and employment of AFDC recipients as homemakers/home health aides on subsequent, continued, and nonsubsidized employment.
- Assess the costs and outcomes of providing home health aide services to persons at risk of institutionalization who would otherwise not receive these services.
- Assess the net cost effectiveness and provide policy-relevant projections on large-scale implementation.

Status: The contractor has completed five major deliverables: a data resources report; a report on issues in the design implementation; the final research design; and the first-year report, "Planning and Initial Implementation Experience." This report is a descriptive analysis of the seven States' first-year activity. Individual State case studies were also completed. The second-year annual report was completed in August 1984. The report summarizes the States' experiences in terms of their operational characteristics and the status and characteristics of the participants. A report on health status outcomes is expected in January 1986. Another report, assessing the effects of the demonstration on nursing home stays, is expected in March 1986. A cost-benefit analysis will be completed in June 1986, and a summary of all evaluation findings will be completed in August 1986.

Other Long-Term Care

Bioactuarial Estimates and Forecasts of Health Care Needs and Disability

Project No.: 18-P-97710/4-04
Period: June 1980 - July 1986
Funding: $ 599,936
Award: Grant
Grantee: Duke University
2117 Campus Avenue
Durham, N.C. 27706
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This project employs bioactuarial methods to estimate the need for various types of health services including long-term care. The determinations of levels of need are employed in analyses of the health status of small geographic areas as well as in national projections. The project is also examining how need estimates are being translated into utilization of nursing homes. These applications of bioactuarial strategies for forecasting population change in health status represent an extension of the grant's basic work.

Status: Results of this project include estimates and projections of the incidence and prevalence of specific chronic diseases (for example, cancer) among the elderly population. In addition, the study has provided new insights on the flow of the elderly population through the nursing home system (for example, admission rates and lengths of stay). Finally, the project is developing profiles of the elderly population in terms of the likelihood of their using alternative modes of long-term care. The National Medical Care Utilization and Expenditure Survey and the Long-Term Care Survey, both Health Care Financing Administration-funded efforts, have applied this methodology. Currently, 16 publications have been written under this grant:

- "Bioactuarial Models of National Mortality Time Series Data: Strategies for Making Full Information Estimates of National Morbidity Distributions," Health Care Financing Review, Fall 1982.
- "The Use of Mortality Time Series Data to Produce Hypothetical Morbidity Distributions and Project Mortality Trends," Demography, Vol. 19, 1982.
- "The Characteristics and Utilization Pattern of an Admission Cohort of Nursing Home Patients," Gerontologist, Vol. 24, 1983.
- "Length of Stay Pattern of Nursing Home Admissions," Medical Care, Vol. 21, 1983.
- "Compartment Model Methods in Estimating Costs of Cancer," Transactions Society of Actuaries, Vol. 34, 1983.
- "The Characteristics and Utilization Pattern of an Admissions Cohort of Nursing Home Patients II," Gerontologist, Vol. 24, 1984.

- "Methods and Issues in the Projection of Population Health Status," prepared for World Health Organization Division of Epidemiological Surveillance and Health Situation and Trend Assessment, World Health Statistics Quarterly, No. 3, 1984.

- "Projecting Chronic Disease Prevalence," Medical Care, Vol. 22, 1984.

- "Strategies for Collating Diverse Scientific Evidence in the Analysis of Population Health Characteristics: Bioactuarial Models of Chronic Disease Mortality for the Elderly," Sociological Methods and Research, Sage, Vol. 13, No. 3, 1984.

- "The Economic Impact of Health Policy Interventions," Risk Analysis, Vol. 3, No. 4, 1983.

- "Life Table Methods for Assessing the Dynamics of Nursing Home Utilization: 1976-1977," J. Gerontology, Vol. 39, 1984.

- "Morbidity, Disability, and Mortality: The Aging Connection," Aging 2000: Our Health Care Destiny, Vol. 2, Springer-Verlag, New York, 1985.

- "An Analysis of the Heterogeneity of U.S. Nursing Home Patients," J. Gerontology, Vol. 40, 1985.

- "Dynamics of Health Changes in the Extreme Elderly: New Perspectives and Evidence," Special issue on the oldest old. Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring, 1985.

- "The Use of Grade of Membership Analysis to Evaluate and Modify Diagnosis-Related Groups," Medical Care, Vol. 22, No. 12, Dec. 1984.

- "Analytic Approaches for Determining Incidence from Prevalence and Reported Disease Duration," Journal of the American Statistical Association, to be published.

Final year efforts are directed toward the development of explanatory models of stability and change among Supplemental Security Income recipients who became institutionalized in Medicaid certified facilities. This includes variations in lengths of stay, turnover patterns, and mortality rates. Analyses will separately examine the aged, blind and disabled adults, and disabled children. Plans have been made to incorporate analyses of data from long-term care, case-mix demonstrations in New York and Texas.

Comparison of the Cost and Quality of Home Health and Nursing Home Care

Project No.:	18-P-97712/8-04
Period:	June 1980 - December 1986
Funding:	$ 1,578,683
Award:	Grant
Grantee:	University of Colorado 1355 South Colorado Boulevard, Suite 706 Denver, Colo. 80222
Project Officer:	Philip Cotterill Division of Reimbursement and Economic Studies

Description: This study assesses the cost, quality, and cost effectiveness of nursing home and home health care provided by freestanding agencies and hospital-based facilities. Detailed data on patient conditions and services were collected for a sample of nursing home and home health patients from the following States: Arkansas, California, Colorado, Florida, Michigan, Minnesota, New York, Ohio, Pennsylvania, and Virginia. A subset of patients will be tracked over time to observe outcomes.

Status: During the third year, additional data on Medicare patients in skilled nursing facilities (SNF's) were collected so that case-mix comparisons could be made between Medicare and non-Medicare patients in hospital-based and freestanding facilities. The University of Colorado sampled 600 patients in high-volume Medicare SNF's in five States (California, Pennsylvania, Ohio, Michigan, and Texas), and 600 non-Medicare patients in hospital-based and freestanding nursing homes in 10 States (Arkansas, California, New York, Michigan, Minnesota, Colorado, Florida, Virginia, Pennsylvania, and Ohio). From these studies of case-mix differences, the following patterns emerge:

- Medicare patients are more seriously ill from a medical perspective and possess greater rehabilitation potential than other long-term care patients.
- Non-Medicare patients tend to be more dependent in functions, as measured by activities of daily living (ADL's), and have more traditional long-term care problems (e.g., impaired mobility, depression, and mental problems).
- In general, patients in hospital-based nursing homes tend to be more dependent in ADL's, have more traditional long-term care problems, and have more medically oriented problems than do patients in freestanding nursing homes.

More detailed results are presented in a report entitled, "Nursing Home Case-Mix Differences for Medicare Versus Non-Medicare and Hospital-Based Versus Freestanding Patients." Currently, the project is assessing the cost effectiveness of nursing home and home health care for patients with the following problems: stroke, decubitus ulcers, congestive heart failure, urinary incontinence, and mental status problems. Emphasis is being placed on comparing outcomes for these patients over time between hospital-based and freestanding nursing home care, and nursing home and home health care. A report on this analysis is expected early in 1986. During 1986, additional case-mix data will be collected to permit an analysis of changes in nursing home and home health case mix since the introduction of the Medicare prospective payment system for hospitals in 1983. Results are expected early in 1987.

Encouraging Appropriate Care for the Chronically Ill Elderly: A Controlled Experiment to Evaluate the Impacts of Incentive Payments on Nursing Home Admissions, Discharges, Case Mix, Care, Outcomes, and Costs

Project No.: 11-P-97931/9-04
Period: April 1981 - June 1986
Award: Grant
Grantee: State of California Department of Health Services
714-744 P Street
Sacramento, Calif. 95814
Project Officer: Tony Hausner
Division of Long-Term Care Experimentation

Description: This project is testing a system of incentive payments as a means of encouraging skilled nursing facilities (SNF's) in San Diego to admit and provide quality care to severely dependent patients. Many patients have more lengthy hospital stays than appropriate because of the amount and cost of care these patients would require in an SNF. Health Care Financing Administration waivers permit SNF rates which exceed the Medicaid cost limits by the incentive amounts. Under the terms of the contracts with these SNF's, the incentive payments for patients admitted during the first project year will continue for up to 4 years from the date of admission (1986), if the patient remains in the facility. The National Center for Health Services Research (NCHSR) provides total project funding.

Status: The intake of patients ended April 30, 1982. Patient reassessments continued through April 30, 1983. Final editing and analysis of the data are now completed. Waivers will end in June 1986. As of July 1985, the participating SNF's were receiving the admission incentive payments for 20 Medicaid patients under the demonstration. The first of three evaluation reports has been received, "Nursing Home Admissions: The Results of an Incentive Reimbursement Experiment, NCHSR, (PHS) 86-3397, October 1985.

Effects of Alternative Family Support Strategies

Project No.:	95-C-98281/0-03
Period:	May 1983 - March 1987
Funding:	$ 396,531
Award:	Cooperative Agreement
Awardee:	University of Washington Institute on Aging Seattle, Wash. 98195
Project Officer:	Don Sherwood Division of Long-Term Care Experimentation

Description: The purpose of this project is to study the effects of support programs provided to families that care for their elderly members at home. The demonstration will assess the impact of three support strategies: paid respite care, family training and case management, and a combination of respite care with training and case management. The paid respite care includes services provided by a home health agency, three adult day-care centers, and a skilled nursing facility. Families may use any mix of the respite services, up to a maximum dollar limit, for a period of 12 months. Key outcome variables to be measured are family burden, length of time families serve as primary caregivers, propensity toward institutionalization, and cost of long-term care services.

Status: By December 1983, the University had satisfied the terms and conditions of the Health Care Financing Administration's (HCFA) approval of this demonstration. Admissions to the project began in March 1984, and the paid respite services began in April 1984. However, unexpected problems with the recruitment of participants has delayed the project timeline. The University project staff has found that many of the patients and families who are appropriate to participate in the project are very independent and relatively isolated from the social and health service systems. As a result, these families are very difficult to reach except through the mass media. The last media campaign for this project brought the number of participants up to a total of 541 in July 1985, and the University then ended admissions to the project. HCFA has approved a continuation of the demonstration respite services through July 1986 to allow late enrollees sufficient time to use the respite services. The evaluation of the demonstration is projected for completion by March 1987.

Analysis of Long-Term Care Payment Systems

Project No.:	18-C-98306/8-03
Period:	April 1983 - June 1987
Funding:	$ 1,380,959
Award:	Cooperative Agreement
Awardee:	Center for Health Services Research University of Colorado 1355 South Colorado Boulevard, Suite 706 Denver, Colo. 80222
Project Officer:	Judith Sangl Division of Reimbursement and Economic Studies

Description: This project is a comparative analysis of long-term care reimbursement systems in seven States (Colorado, Florida, Maryland, Ohio, Texas, Utah, and West Virginia). The study will combine an empirical analysis of nursing home costs and payments and the determinants of costs with a detailed qualitative analysis of the operations of the reimbursement systems. The comparative analysis across States will be performed through a unique "comparison-by-substitution" method that calculates reimbursement for nursing homes in one State under the assumption that the other States' reimbursement systems are in effect. Data sources for this study include primary facility information and patient samples, as well as secondary sources such as cost reports.

Status: Major project activities include:

- Collection of updated information on the study States' nursing home reimbursement methodology. Information on capital payment methodologies was also collected.
- Collection of Medicaid cost report and payment rate information for facilities.
- Revision of patient data collection instrument to obtain the information necessary to categorize patients according to the resource utilization group methodology.

Six reports have been prepared:

- "Case-Mix Measures and Medicaid Nursing Home Payment-Rate Determination in West Virginia, Ohio, and Maryland."
- "Overview of Medicaid Nursing Home Reimbursement Systems."
- "Case-Mix and Capital Innovations in Nursing Home Reimbursement."
- "An Analysis of Long-Term Care Payment Systems: Research Design."
- "Medicaid and Non-Medicaid Case-Mix Differences in Colorado Nursing Homes."
- "Case-Mix Reimbursement for Nursing Home Services: A Three-State Simulation Model."

Long-Term Care of Aged Individuals With Hip Fractures: Public Versus Private Costs

Project No.: 18-C-98393/3-03
Period: September 1983 - September 1986
Funding: $ 604,152
Award: Cooperative Agreement
Awardee: University of Maryland Medical School
655 West Baltimore Street
Baltimore, Md. 21201
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: This study is examining, in detail, the complex economic and psychosocial determinants of the public and private contribution to the long-term care of a group of aged individuals who suddenly become disabled by hip fractures. The impact of family size and composition, social support, family economic resources, and the aged individual's physical and mental health will be analyzed in terms of the decision to enter a nursing home or return home.

Status: Baseline interviews for 318 patients (one-half of the projected sample) as well as many of the followup interviews have been completed. Information has been obtained about health insurance benefits available to the Maryland study subjects from the four major insurance companies in the area and from the State concerning Medicaid. Preliminary data analysis has begun.

Responsibility of Children for Financing Institutional Care: Potential Response and Possible Adjustments

Project No.: 18-C-98375/1-02
Period: November 1983 - May 1985
Funding: $ 80,000
Award: Cooperative Agreement
Awardee: Hebrew Rehabilitation Center for the Aged
1200 Centre Street
Boston, Mass. 02131
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: The objective of this project is to determine the barriers to and potential for alternate payment schemes for long-term care, particularly nursing home care, by the children of the elderly. The research will:

- Provide an estimate of children's resources available to share in the costs of long-term care.
- Assess the attitudes of those children toward proposals for sharing in the costs of their parents' long-term care and identify factors associated with those who have positive and negative feelings.
- Assess the market for a new type of insurance for nursing home care, and identify factors associated with those who are and are not interested in such insurance.

Status: Interviewing was completed in December 1984, and data analysis has begun. The final report will be available in early 1986.

Can Geriatric Nurse Practitioners Improve Nursing Home Care?

Project No.:	18-C-98379/9-02
Period:	September 1983 - February 1987
Funding:	$ 573,760
Award:	Cooperative Agreement
Awardee:	The Rand Corporation 1700 Main Street Santa Monica, Calif. 90406
Project Officer:	Judith Sangl Division of Reimbursement and Economic Studies

Description: The purpose of the study is to evaluate the potential of the use of geriatric nurse practitioners (GNP's) for improving outcomes of care and containing costs in skilled nursing facilities. The 30 nursing homes that participated in the Mountain States Health Corporation's GNP demonstration project will be compared with 30 nursing homes in the region that did not participate. Comparisons will be made of:

- Patient outcomes.
- Process of care.
- Nursing home costs.
- History of certification deficiencies.

Homes will be matched by State, ownership, bed size, and urban, suburban, or rural location.

Status: Two-thirds of the prospective patient interviews have been completed and preliminary analysis of the data from the prospective study has begun. Record review for the pre-GNP year has been completed and record review for the post-GNP years has begun. Case study interviews with nursing home administrators, directors of nursing, and GNP's have been completed and are being analyzed.

Case-Managed Medical Care for Nursing Home Patients

Project No.: 95-P-98346/1-03
Period: July 1983 - July 1986
Award: Grant
Grantee: Massachusetts Department of Public Welfare
180 Tremont Street
Boston, Mass. 02111
Project Officer: Jean L. Bainter
Division of Long-Term Care Experimentation

Description: The Health Care Financing Administration granted Medicare and Medicaid waivers to the Massachusetts Department of Public Welfare to permit fee-for-service reimbursement for the provision of medical services by physician-supervised nurse practitioners/physician assistants for residents of nursing homes. This will permit increased medical monitoring that is expected to generate cost savings as a result of fewer hospital admissions and hospital outpatient visits.

Status: The first year of this project was a developmental phase, which included marketing the concept to other providers (individual physicians and groups) and to nursing home administrators. During the second year, 11 additional providers joined the project. The patient population is expected to reach 2,500 in 75-100 nursing homes. The Rand Corporation will carry out a service utilization and cost evaluation. Quality of care implications will also be examined by Rand.

Study of Long-Term Care Quality and Reimbursement in Teaching and Nonteaching Nursing Homes

Project No.: 18-C-98417/8-02
Period: September 1983 - September 1986
Award: Cooperative Agreement
Funding: $ 808,176
Awardee: University of Colorado Health Sciences Center
4200 East 9th Avenue, C-421
Denver, Colo. 80262
Project Officer: Kathy Ellingson
Division of Long-Term Care Experimentation

Description: This study evaluates the Teaching Nursing Home Program (TNHP) sponsored by the Robert Wood Johnson Foundation. The purpose of the TNHP is to improve the health care provided to long-term care patients. Eleven university-based schools of nursing were funded to establish clinical affiliations with one or two nursing homes. This study evaluates the impact of the affiliations on patient outcomes and costs of patient care. Specifically, the study will assess the extent to which the TNHP approach reduces hospitalizations and emergency room care; decreases length of nursing home stays and increases discharge into independent living environments; and enhances health status. A net cost-benefit ratio will be determined.

Status: Refinement of the study design, selection of comparison nursing homes, and development of primary data-collection instruments were the main activities during the first year. A programmatic analysis providing an indepth look at how the TNHP was implemented and operating in different facilities was completed in January 1985. All primary data collection instruments have been developed and the main activities of the study are currently focused on data collection, processing, and monitoring.

Massachusetts Health Care Panel Study of Elderly--Wave IV

Project No.:	18-C-98592/1-02
Period:	July 1984 - June 1986
Funding:	$ 152,408
Award:	Cooperative Agreement
Awardee:	Harvard University/Harvard Medical School 1350 Massachusetts Avenue Holyoke Center 458 Cambridge, Mass. 02138
Project Officer:	Marni Hall Division of Reimbursement and Economic Studies

Description: This project will collect the fourth wave of self-reported information from the Massachusetts Health Care Panel Study cohort, a group that was selected 10 years ago as a statewide probability sample of all persons 65 years of age or over. The data from the first three waves were analyzed and the results have been reported in numerous articles in professional journals. In this project, the data from all four waves will be analyzed to determine markers of functional decline during pre-death, predictors of long-term care institutionalization, and interrelationships between physical, behavioral, and social characteristics and subsequent health care and social service utilization and mortality.

Status: All of the data for this project have been gathered. Coding, keypunching, and cleaning of the data tape are in the final stages. Analysis of the data is under way, and a final report is expected in June 1986.

Quality of Life Among Life-Care Facility and Community Residents: A Comparison

Project No.:	18-C-98630/4-01
Period:	November 1984 - February 1986
Funding:	$ 28,539
Award:	Cooperative Agreement
Awardee:	Duke University Medical Center Center for the Study of Aging and Human Development Box 3003 Durham, N.C. 27710
Project Officer:	Judith Sangl Division of Reimbursement and Economic Studies

Description: The objective of this project is to determine whether living in a life-care facility (where, typically, life-long care is assured and services are accessible) has an impact on residents' quality of life (defined in terms of functional status), that make it significantly different from that of community residents, and whether the services used and the cost of maintaining or attaining a particular functional status is the same for life-care residents as for matched community residents. The study will use longitudinal data collected from a life-care facility in North Carolina and from the General Accounting Office survey of elderly people in Cleveland, Ohio.

Status: The final report is expected in early 1986.

An Evaluation of "Life-Continuum of Care" Residential Centers in the United States

Project No.: 18-C-98672/1-01
Period: January 1985 - January 1988
Funding: $ 806,366
Award: Cooperative Agreement
Contractor: Hebrew Rehabilitation Center for Aged
1200 Centre Street
Boston, Mass. 02131
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: The objective of this 3-year project is to obtain information about the characteristics of Continuum of Care Residential Center (CCRC) facilities and their residents and compare them with elderly residents living in the community with respect to quality of life and health, service costs, and utilization. Data will be gathered from 20 CCRC's in four areas: California, Arizona, Florida, and Pennsylvania. These sites will be stratified according to the type of contract offered (extended versus limited), the age of the facility, and the income level of those enrolled. Three types of CCRC residents will be selected from the sites for the study sample: new admissions (580), existing residents (both short- and long-stay residents) (1,640), and residents who died just prior to or during the field data gathering period (660). Quality of life and service utilization data will be gathered at two points in time, at baseline and 12 months later. Three types of comparison samples will be employed: a representative sample of elderly in their own homes or independent apartments (2,422); a national sample of elderly living in congregate housing settings (2,350); and a representative sample of elderly who have died, and for whom retrospective data are available for their last year of life (1,500).

Status: The project began in January 1985 and is in its developmental stage.

Long-Term Care Client Targeting Manual

Project No.:	500-84-0062
Period:	October 1984 - April 1985
Funding:	$ 25,000
Award:	Contract
Contractor:	Berkley Planning Associates 3200 Adeline Street Berkley, Calif. 94703
Project Officer:	David Schwartz Division of Research and Demonstrations Systems Support

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). The project was to develop a detailed outline and product testing plan for a long-term care client-targeting manual. During the initial phase, the contractor redefined findings from earlier studies into forms and examples regarding the selection of a user population and the development of a comprehensive plan for field testing.

Status: The work to be performed was completed in April 1985. Phase II of the project was not funded.

A Voucher Insurance Plan to Mobilize Volunteer Support Among the Elderly

Project No.:	500-84-0064
Period:	May 1985 - December 1987
Funding:	$ 102,806
Award:	Contract
Contractor:	Berkeley Planning Associates 3200 Adeline Street Berkeley, Calif. 94703
Project Officer:	David Schwartz Division of Research and Demonstrations Systems Support

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). The project is to develop a voucher insurance plan to mobilize voluntary support services among elderly Medicare beneficiaries. An individual would earn a voucher by providing volunteer services for other elderly individuals. These vouchers could then be redeemed when an individual becomes ill and requires assistance. A coordinator would handle the vouchers and the dispatching of volunteers. Phase II will have the voucher insurance plan (VIP) implemented, tested, and refined. The contractor will perform the following tasks:

- Development of computer software to match volunteers with recipients and maintain accounts.
- Development of a "How to Operate a VIP" manual.
- Development and marketing of a brochure to promote the VIP among prospective members.

Status: Phase I of the project was completed in April 1985. Phase II will be funded under the Small Business Innovation Research program.

Comparison by State of SNF/ICF Types: Beds, Staffing, Utilization, and Ownership

Funding: Intramural
Project Director: Elizabeth S. Cornelius
Division of Long-Term Care Experimentation

Description: This project unduplicated the count of skilled nursing facilities (SNF's), intermediate care facilities (ICF's), and their respective beds for 1981. The facility and bed count are based on the Medicare/Medicaid Automated Certification System (MMACS) data as of May 31, 1981. Full-time equivalents for registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, pharmacists, qualified social workers, and dietitians have also been identified. A staffing matrix showing the relationship to current staffing regulations was developed. In addition, a staffing matrix, using number of beds to nurse staffing ratios, was tested in 1981. The project was conducted in conjunction with a project funded by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services, which evaluated the usefulness of the MMACS system for research and policy-analysis purposes. The intramural analysis examined State-by-State differences in:

- Types of certified, long-term care facilities (SNF only, SNF/ICF combination, and ICF only).
- Certified bed supply in relation to the population and total long-term care bed supply.
- Professional staffing levels.

The analysis will also identify what percent of the total certified beds were used by Medicare, Medicaid SNF, and Medicaid ICF patients, during fiscal year 1981. Updating and unduplicating of the 1984 and 1985 files has been approved so that bed supply and staffing can be compared for a 3-year period that involves both pre- and post-diagnosis-related group payment of hospitals.

Status: The ASPE evaluation has been completed, and the final report has been accepted by the Department. The evaluation found that the staffing data are acceptable for a State-level analysis. An unduplicated tape has been prepared and tables have been constructed. The staffing data have been cross checked with the Master Facility Inventory File maintained by the National Center for Health Statistics, and a research file at Columbia University. A comparison of the bed data has been made with the 1980 and 1982 Master Facility Inventory. The data match and thus enable a comparison of total long-term care beds to certified beds. The unduplicated file is being used by several grantees and contractors relative to nursing home supply and demand studies. The 1984 and 1985 files are being checked against State licensure directories and unduplication is complete for 50 percent of the States. These files should be available in Spring 1986. By 1986, changes in the entry processing method of the MMACS Master File will be completed. The revised method will allow better comparison of the ongoing data.

ALTERNATIVE PAYMENT SYSTEMS

Competition

A Demonstration of Cost Control and Patient Satisfaction Resulting from the Relaxation of the Maximum Public Enrollment Rule for HMO's

Project No.: 11-P-97986/5-03
Period: April 1981 - March 1985
Award: Grant
Grantee: Michigan Department of Social Services
300 South Capitol Avenue
P.O. Box 30037
Lansing, Mich. 48909
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: The purpose of this demonstration is to test the effects on the cost and quality of care in health maintenance organizations (HMO's) resulting from the relaxation of the regulation requiring that Medicare and Medicaid beneficiaries cannot exceed 75 percent of total HMO enrollment. The project will compare the quality of care provided in HMO's exceeding the limit with HMO's conforming to the regulation through the use of satisfaction surveys.

Status: A final report for the project was received in May 1985. The findings included the following:

- The level of satisfaction of recipients was high for both HMO's in the survey.
- Although the overall satisfaction level was high, there was still a significant difference in the level of client satisfaction between the two HMO's. Recipients in the HMO that met the required enrollment percentage mix were more satisfied with the services they received then were the recipients in the HMO that exceeded the maximum percentage limit of public beneficiaries. The State suspects, however, that there may have been factors other than enrollment mix which affected the outcome.
- There was a significant cost saving to the Medicaid program by contracting with the HMO's. During February of 1983, an average of $8.11 per enrolled recipient was saved by the program through relaxation of the enrollment-mix requirement.

Test of the Out-of-Pocket Cost Savings as an Incentive for Changing Beneficiary Choice Behavior

Project No.: 17-C-98392/3-02
Period: September 1983 - September 1986
Funding: $ 709,316
Award: Cooperative Agreement
Awardee: Morgan State University
Institute for Urban Research
Baltimore, Md. 21239
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: The project is designed to develop basic knowledge on how elderly health care consumers obtain and process information, and how they balance various factors when making decisions under Medicare. The project has four objectives:

- To investigate ways of making beneficiaries more cost conscious.
- To examine the impact of information on expected out-of-pocket costs on beneficiary choice and behavior.
- To devise optimal approaches for beneficiaries to use in approaching their providers.
- To train beneficiaries in these techniques and test their effect.

Status: The project's accomplishments to date included the first year activities of refinement of the research design, completion of the literature search, local data collection, development of the out-of-pocket cost model, identification of the pre-enrollee sample source, and the physician's survey. Second year tasks recently completed were the physician's survey, the Medicare pre-enrollee survey, development of out-of-pocket costs from an actuarial model, development of training materials for use in the in-person information seminars, and the informative telephone seminars. Third year tasks are scheduled to include analysis of pre-enrollee survey data, preparation of a report on pre-enrollee survey data, the holding of informative seminars with new Medicare beneficiaries, a post-choice study, a post-choice experience telephone survey, the development of a list of policy papers with review by the Health Care Financing Administration, and preparation of a final report.

American Association of Retired Persons' Informed Buyer Program

Project No.:	18-P-98391/3-01
Period:	September 1983 - June 1986
Funding:	$ 256,080
Award:	Grant
Grantee:	American Association of Retired Persons P.O. Box 19269 Washington, D.C. 20036
Project Officer:	Kathleen Farrell Division of Health Systems and Special Studies

Description: This demonstration project is designed to sensitize health maintenance organizations (HMO's) to offer an improved benefit package for the Medicare-eligible population. This will be accomplished in five sites by educating and training older volunteer health advocates about the HMO option and by assisting these advocates in persuading the HMO's to offer a benefit package attractive to Medicare beneficiaries. In addition, a community-wide education program will be implemented to inform Medicare beneficiaries about the HMO option and how to compare it with other health care options, and to encourage them to review their current coverage in light of this new information.

Status: The following sites have been selected: San Francisco/Oakland, Calif.; Bridgeport, Conn.; Tampa, Fla.; Detroit, Mich.; and Philadelphia, Pa. Volunteer coordinators have been recruited and trained in each site and are conducting educational programs on the HMO option. Using volunteers to advocate an enriched Medicare benefit package in HMO's was delayed until the second year of operation when the Tax Equity and Fiscal Responsibility Act of 1982 regulations were implemented; it was started in August 1985. To date, 2,400 Medicare beneficiaries in the five sites have received education programs on HMO's. An evaluation is being conducted by AARP on the effectiveness of the beneficiary awareness program.

Health Care Alternatives Within Title XIX: Evaluation of Alternative Reimbursement Methods to Providers of Primary Care Medical Services

Project No.:	**11-C-98321/5**
Period:	**April 1983 - March 1986**
Funding:	**$ 585,675**
Award:	**Cooperative Agreement**
Awardee:	**Michigan Department of Social Services 300 South Capitol Avenue Lansing, Mich. 48909**
Project Officer:	**Gerald S. Adler Division of Beneficiary Studies**

Description: The study will examine the consequences of enrollment in innovative medical care organizations for the cost, effectiveness, quality, and accessibility of medical care provided to Medicaid populations in Michigan. The organizational types to be compared are:

- Health maintenance organizations (HMO's).
- Capitated ambulatory plans (CAP's) that do not cover inpatient, dental, long-term care, or personal care.
- Physician's primary sponsor plans (PPSP's) that feature case management, although care is paid for on a fee-for-service basis.

These organizations form a continuum of provider risk, and they are to be compared with standard fee-for-service care.

Status: A sample of 20,000 Medicaid recipients in Wayne County, Mich., has been drawn, with 10,000 randomly assigned to the PPSP and 10,000 to the comparison group. Enrollment in the PPSP program has grown more slowly than expected. Preenrollment studies of patient satisfaction and physician attitudes have been conducted. Data collection for the study period is under way.

Demonstration and Evaluation of Competitive Bidding as a Method of Purchasing Durable Medical Equipment

Project No.: 500-85-0050
Period: September 1985 - September 1990
Funding: $ 1,489,661
Award: Contract
Contractor Abt Associates
4250 Connecticut Avenue
Washington, D.C. 20008
Project Officer: Jeff McCombs
Division of Hospital Experimentation

Description: The project will test the feasibility of using competitive bidding as a method of establishing the prices Medicare pays for durable medical equipment. The project consists of a 1-year design phase, a 3-year operational phase, and a 1-year phase in which final evaluation reports will be completed.

Status: The decision on whether to implement the demonstration will be made after the final design is approved and Medicare waivers are sought for the project.

Demonstration and Evaluation of Competitive Bidding as a Method to Purchase Clinical Laboratory Services

Project No.: 500-85-0052
Period: September 1985 - September 1989
Funding: $ 1,509,605
Award: Contract
Contractor: ABT Associates, Inc.
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: Paul A. Gurny
Division of Hospital Experimentation

Description: The project will test the feasibility of using competitive bidding as a method to purchase clinical laboratory services in specific areas. It should provide the Health Care Financing Administration with considerable information on whether the current Medicare fee schedule for clinical laboratory tests is set at a proper level, and also provide valuable information on the utility of a relative value scale (RVS) for laboratory services. The project consists of three phases:

- Phase I - Finalize the bidding model design, select demonstration sites, develop an RVS, and prepare bidding documents.
- Phase II - Administer the bidding systems.
- Phase III - Evaluate the demonstration.

The total time for the demonstration is 4 years. The objectives of the demonstration are to increase competitive forces, reduce costs, and place Medicare in the position of a prudent buyer.

Status: The contract for this outpatient clinical laboratory, competitive-bidding demonstration and evaluation was awarded in September 1985. Phase I of the project has been funded. A decision on whether to proceed into Phase II will depend on a review of the final design and the approval of the project waivers.

Independent Broker: Coordinating Open Enrollment for Medicare Health Maintenance Organizations and Competitive Medical Plans

Project No.:	95-C-98750/0-01
Period:	September 1985 - August 1988
Funding:	$ 276,173
Award:	Cooperative Agreement
Awardee:	HealthChoice, Inc. 621 S.W. Alder, Suite 820 Portland, Oreg. 97205
Project Officer:	Kathleen Connors Division of Health Systems and Special Studies

Description: This project will test the efficacy of an independent broker conducting a coordinated open enrollment period for Medicare beneficiaries. The broker will produce and distribute information comparing the options available under the Medicare program for Medicare eligibles and Medicare/Medicaid dually eligibles. Los Angeles and San Francisco, California, are the two sites the Health Care Financing Administration has chosen for the demonstration to be implemented. This is the third broker demonstration and varies from the other two in that the broker will only coordinate health maintenance organization fairs and perform other marketing functions for at least three Tax Equity and Fiscal Responsibility Act alternative health plans (AHP's) in each of the two cities. HealthChoice will not be providing indepth beneficiary counseling and/or enrollment functions as in previous demonstrations.

Status: This project is in the developmental stage with HealthChoice in the process of contacting AHP's to affirm their commitment to participate in the project. The projected open enrollment period is scheduled for May 1986 in San Francisco and September 1986 in Los Angeles.

Information for Prudent Insurance Choices

Project No.:	18-C-98686/9-01
Period:	November 1984 - March 1986
Funding:	$ 300,000
Award:	Cooperative Agreement
Awardee:	Western Consortium for the Health Professions, Inc. 703 Market Street, Suite 535 San Francisco, Calif. 94103
Project Officer:	Aurora Zappolo Division of Program Studies

Description: The purpose of this project is to develop an informational document that increases the capacity of aged Medicare beneficiaries to make prudent choices in selecting supplemental health insurance coverage. The document will permit comparisons of out-of-pocket costs and benefits of alternative plans. The comparisons will be based on "scenarios" involving episodes of illnesses common to the aged.

Status: Thirteen common illnesses have been identified. Common diagnostic and treatment procedures of each illness have been delineated. The next step will involve development of model costs for each episode of illness.

Capitation Payment System for All End-Stage Renal Disease Services

Project No.: 95-C-98497/9-01
Period: January 1985 - December 1989
Funding: $ 380,000
Award: Cooperative Agreement
Awardee: El Camino Hospital District Corporation
2500 Grant Road
Mountain View, Calif. 94042
Project Officer: Marla Aron
Division of Health Systems and Special Studies

Description: This project will develop and test a competitive capitation program under which capitation payments would cover all Medicare benefits to end-stage renal disease (ESRD) patients (including transplants). The awardee will negotiate a capitation rate with the Health Care Financing Administration (HCFA) at 95 percent of the estimated Medicare fee-for-service cost. A delivery system similar to a health maintenance organization will be developed and will include case management for ESRD patients, patient incentives, physicians' incentives and risk taking, preferred provider contracts, and quality assurance measures.

Status: The awardee is preparing to negotiate capitation rates with HCFA.

Design of a Demonstration and Assessment of Competitive Health Insurance Proposals in the End-Stage Renal Disease Program

Project No.:	14-P-98275/3-01
Period:	April 1983 - March 1987
Funding:	$ 879,694
Award:	Grant
Grantee:	The Urban Institute 2100 M Street, NW. Washington, D.C. 20037
Project Officer:	Marla Aron Division of Health Systems and Special Studies

Description: This project will determine the feasibility of demonstrations to test competitive financing approaches in the end-stege renal disease (ESRD) program, with possibilities including:

- Competitive bidding.
- Global capitation covering all medical care costs.
- Partial capitation covering only outpatient ESRD services.
- Voucher payment allowing patients to share in the financial savings of cost-reducing shifts.

If competitive approaches are feasible, the Urban Institute will develop the demonstration model and an evaluation design. The evaluation will consider:

- Structure of the experimental treatments.
- Methods to ensure randomization.
- Determination of appropriate capitation amounts.
- Design of a reinsurance system.
- Estimate of sample sizes.

Status: The grantee assisted the Health Care Financing Administration in the development of its intramural end-stage renal disease competitive bidding demonstration. The grantee has also submitted preliminary reports on the competitive bidding models. These reports provide the conceptual background and consider practical implementation issues of the various bidding models. An evaluation report will be available in 1986.

End-Stage Renal Disease Competitive Bidding Demonstration

Funding: Intramural
Project Directors: Thomas A. Noplock and Marla Aron
Division of Hospital Experimentation and
Division of Health Systems and Special Studies

Description: The Health Care Financing Administration (HCFA) implemented a competitive bidding demonstration for end-stage renal disease maintenance dialysis services in two site locations. The project involved independent and hospital-based providers of outpatient maintenance dialysis services in the areas. Each facility was asked to submit a bid for providing maintenance dialysis services to Medicare beneficiaries, not to exceed the Medicare composite rate for independent facilities. The approved competitive bid rate served as the basis of Medicare reimbursement to the facility. Beneficiaries were eligible to receive a cash incentive payment equal to 70 percent of the difference between the composite rate for independent facilities and the bid rate of the facility. If a facility did not submit a bid, or submitted a bid higher than the composite rate, the facility continued to receive its normal composite rate payment and the beneficiary could elect to receive care at that facility or change to a facility participating in the demonstration. The demonstration plans to test whether the potential for increased case loads will induce facilities to bid lower prices and whether the availability of cash incentives will induce beneficiaries to seek lower-priced facilities.

Status: Implementation of the demonstration began April 1, 1985. One facility in Denver chose to participate. No facility in Riverside submitted a bid. In July, the Community Dialysis Services of Denver, the single participating facility, notified HCFA that it would not renew its bid because the facility had not received any new patients as a result of the demonstration. Therefore, the demonstration terminated on September 30, 1985, when the current bidding period ended. Evaluation data are being collected and will be analyzed by the Urban Institute.

Medicare Competition Projects

Medicare Prospective Capitation Demonstration Project

Project No.: 95-P-98147/4-03
Period: April 1982 - March 1985
Award: Grant
Grantee: International Medical Centers, Inc.
1505 167th Street, N.W.
Miami, Fla. 33169
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: This project demonstrated and tested an alternative to traditional Medicare financing and health care delivery in South Florida. The health maintenance organization (HMO) provided covered Medicare benefits for an amount of reimbursement equal to 95 percent of the adjusted average per capita cost. Extra benefits were offered to Medicare beneficiaries at little or no cost, including dental benefits, eyeglasses, hearing aids, prescription drugs, and transportation to the HMO. The project's service area included: Dade, Broward, Palm Beach, Hillsborough, Pasco, and Pinellas Counties.

Status: Preparation for implementation of the demonstration proceeded from April through July 1982. On August 1, 1982, more than 10,000 Medicare beneficiaries were enrolled in the demonstration. These beneficiaries were already enrolled in a Health Care Financing Administration sponsored Section 1876 risk contract. Since that time, International Medical Centers (IMC) averaged more than 2,000 new members per month. IMC served approximately 164,000 members, 118,000 (72 percent) of which were Medicare beneficiaries under the demonstration program. IMC's delivery system included a hospital and nine outpatient health centers owned and operated by IMC, and an additional 131 medical centers/health centers under contract with IMC to provide services. The demonstration ended on March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Enrollment of Medicare Beneficiaries Under a Unique Intra-Health Maintenance Organization Competition Model

Project No.: 95-P-98215/4-03
Period: September 1982 - March 1985
Award: Grant
Grantee: Comprehensive American Care
Health Plan, Inc.
P.O. Box 013140
Miami, Fla. 33101
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project demonstrated and tested an alternative to traditional Medicare financing and health care delivery in Miami. The health maintenance organization (HMO) provided covered Medicare benefits and several extra benefits for an amount of reimbursement equal to 95 percent of the adjusted average per capita cost. A unique feature of the HMO was an enrollee privilege to seek out-of-plan physician services subject to a deductible and copay amount.

Status: The first enrollees in Comprehensive American Care became effective October 1, 1982. There were 6,535 Medicare enrollees in the plan at the end of the demonstration. The plan offered extensive benefits in addition to Medicare, with no monthly premium in Dade and Broward Counties. The demonstration ended on March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Waiver-Only Competition Project for Southern California, Illinois, Indiana, and Texas

Project No.: 95-P-98342/9-02
Period: June 1983 - June 1985
Award: Grant
Grantee: Maxicare Health Plans, Inc.
11633 Hawthorne Boulevard
Hawthorne, Calif. 90250
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: Maxicare Health Plans, Inc., is a for-profit, federally qualified, independent physicians' association model, health maintenance organization based in Hawthorne, Calif. It has agreed to accept 95 percent of the adjusted average per capita cost and enroll beneficiaries in Chicago. California, Illinois, and Texas sites were not included in the demonstration.

Status: Maxicare began enrolling Medicare beneficiaries under this prospective capitation demonstration in Chicago in December 1984. Maxicare offered two benefit packages, with the low option at no premium and the high option at $30.00 per month. The high option differed from the low option primarily by the addition of vision screening and drugs. No deductible and some copayments were charged for services. Enrollment in the Chicago site at the end of the project was 9,000 Medicare beneficiaries. The demonstration period in Illinois ended on June 30, 1985, at which time Maxicare converted to prospective risk capitation under the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Medicare Competition Demonstration

Project No.:	95-P-98445/5-02
Period:	September 1983 - June 1985
Award:	Grant
Grantee:	Share Development Corporation 3600 West 80th Street Bloomington, Minn. 55431
Project Officer:	Ronald Deacon Division of Health Systems and Special Studies

Description: The purpose of this project was to replicate the Share Medicare experience of Minneapolis/St. Paul in Chicago. Share-Illinois is a hospital-based, individual practice association model, health maintenance organization with several group model components. The protocol design phase was completed in Spring 1984, and operations commenced in July. Share was reimbursed 95 percent of the adjusted average per capita cost and offered, in addition to all Medicare Part A and Part B benefits, an expanded benefit package including: unlimited hospital inpatient care; 365 days of skilled nursing facility care; and routine physical, eye, hearing, and foot examinations. The monthly premium was $19.75, with small copays for emergency/urgently needed services and mental health services.

Status: Medicare beneficiary enrollment began in July 1984. Share-Illinois anticipated a total first-year enrollment of 10,000 beneficiaries. The demonstration ended on June 30, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982. Enrollment at the end of the demonstration was 13,000.

Medicare Competition Demonstration

Project No.: 500-82-0037
Period: September 1982 - March 1985
Award: Contract
Contractor: Av-Med, Inc.
9400 S. Dadeland Boulevard
Miami, Fla. 33156
Project Officer: Kathleen Farrell
Division of Health Systems and Special Studies

Description: This project tested alternatives to traditional Medicare financing and delivery of health services in Miami. Av-Med is a federally qualified, individual practice association model, health maintenance organization (HMO) that had a contract to implement a full-risk prepaid capitation demonstration project in Dade and Broward Counties, Fla. Av-Med accepted 95 percent of the adjusted average per capita cost and provided an expanded benefit package with no monthly premium. Av-Med had more than 100 independent practice physicians participating in the demonstration. The HMO intended to enroll at least 5,000 Medicare beneficiaries during each year of the demonstration.

Status: Av-Med began Medicare demonstration enrollment on November 1, 1982. Av-Med expanded to Tampa (counties of Hillsborough, Manatee, Pasco, and Pinellas) and north to Palm Beach County in January 1984. Av-Med had a total of 11,077 Medicare beneficiaries enrolled in the demonstration. The demonstration ended March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-82-0050
Period: September 1982 - March 1985
Funding: $ 363,524
Award: Contract
Contractor: Family Health Program, Inc.
9930 Talbert Avenue
Fountain Valley, Calif. 92708
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: The project was designed to develop and test an alternative model for financing and delivering health care services to Medicare beneficiaries living in southern Los Angeles County and Orange County, Calif. Family Health Program (FHP) is a federally qualified, health maintenance organization (HMO) which proposed to compete for area beneficiaries by making available an attractive benefit package. FHP planned to demonstrate that a clinical facility, designed specifically for a Medicare population, would improve quality of care and would be cost effective. Reimbursement was based on 95 percent of the adjusted average per capita cost.

Status: FHP has enrolled approximately 21,000 Medicare beneficiaries since marketing activities began in September 1983. This demonstration was unique in that FHP constructed a multiservice health care center designed specifically for Medicare beneficiaries. FHP offered two options to beneficiaries--a basic and extended benefit package. The basic plan, which has no monthly premium requirements, covered all Medicare benefits plus preventive services and prescriptions with small copayments. The extended package, offered for a $35 monthly premium, also covered refractions, eyeglasses, podiatry, and dental care and eliminates copayments for basic services. Of the enrollees, 15 percent selected the high option. The demonstration ended on March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.:	**500-82-0043**
Period:	**September 1982 - March 1985**
Award:	**Contract**
Contractor:	**Watts Health Foundation 10300 Compton Avenue Los Angeles, Calif. 90002**
Project Officer:	**Eric R. Nevins Division of Health Systems and Special Studies**

Description: The project was designed to test an alternative model for enhancing competition among providers of care. Watts Health Foundation, through the United Health Plan (UHP), has implemented a competitive demonstration through a contract with the Health Care Financing Administration (HCFA) to provide Medicare beneficiaries in the Los Angeles-Orange County area with a comprehensive set of benefits covering physician services, hospitalization, and other medical services. Reimbursement for services was prospectively determined on a capitation basis. UHP provided all administrative, marketing, quality assurance, and utilization control functions required under this contract.

Status: UHP signed a contract and was granted waivers by HCFA for the operation of a Medicare competition demonstration project in the Los Angeles area. The waivers permitted prospective reimbursement and the delivery of additional benefits offered to Medicare beneficiaries. Watts received reimbursement at 95 percent of what Medicare would normally pay in the fee-for-service system. The project began delivery of services in April 1984. Enrollment at the end of the demonstration was 4,750 beneficiaries. Approximately 500 of these enrollees were crossover Medicare/Medicaid beneficiaries. Traditionally, those who have been served by the UHP were the categorically eligible for Medicaid. The demonstration ended on March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.:	500-82-0051
Period:	September 1982 - September 1987
Funding:	$ 980,646
Award:	Contract
Contractor:	HealthChoice, Inc. 621 SW. Alder Street Suite 820 Portland, Oreg. 97205
Project Officer:	Kathleen Connors Division of Health Systems and Special Studies

Description: This project will test the viability of an independent broker for Medicare beneficiaries in an area (Portland, Oregon) with multiple health plans. Reimbursement will be on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Financing will be on a risk basis. As broker, it markets to beneficiaries and counsels them as to which alternative health plans (AHP's) are available and what benefits each offers. HealthChoice is also testing the impact of a voucher on beneficiaries. Half of the people in the HealthChoice market area will receive a "nonnegotiable" voucher redeemable only at HealthChoice. HealthChoice has also provided assistance to organizations who wished to establish themselves as AHP's.

Status: This project began marketing in February 1985 with two health plans. A third plan began participating in August 1985. As of September 1985, Kaiser Permanente had 624 effective enrollments and Blue Cross/Blue Shield of Oregon had 556. The third plan, Physician Interhospital Health Plan, will have effective enrollments beginning in December 1985. Other plans may participate in the future.

Medicare Competition Demonstration

Project No.:	500-82-0045
Period:	September 1982 - March 1985
Funding:	$ 531,360
Award:	Contract
Contractor:	Blue Cross of Massachusetts 100 Summer Street Boston, Mass. 02106
Project Officer:	Nancy Row Division of Health Systems and Special Studies

Description: This project tested an alternative to traditional Medicare financing and delivery of health services in Massachusetts. Reimbursement was on a prepaid per capita basis, capitated at 95 percent of the adjusted average per capita cost. Under this demonstration, Blue Cross of Massachusetts established a Senior Plan Network of four health maintenance organizations (HMO's) in the State. Each HMO competed with at least one other in its area.

Status: Blue Cross of Massachusetts began enrolling beneficiaries in October 1983. Initial enrollment (6,000 beneficiaries) for two of the plans was double the plans' projections. The demonstration ended on March 31, 1985, and the plans continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982. In March 1985, combined enrollment was 17,332.

Medicare Competition Demonstration

Project No.: 500-82-0034
Period: September 1982 - March 1985
Award: Contract
Contractor: Metro Health, Inc.
931 East 86th Street
Suite 200
Indianapolis, Ind. 46240
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This project tested alternatives to traditional Medicare financing and delivery of health services in Indianapolis. The demonstration was conducted by a federally qualified, staff model, health maintenance organization (HMO) with an enrollment of 78,800 members. The HMO is using one large teaching hospital exclusively for its Medicare enrollees and is implementing a risk-sharing arrangement with the hospital under which the hospital will receive a flat percentage of the adjusted average per capita cost. The Metro Health Plan (MHP) wanted to test the cost effectiveness of competing for Medicare beneficiaries' enrollment in their plan based on offering an expanded package of benefits, including preventive and dental under a prospective capitation reimbursement system.

Status: MHP started enrolling Medicare beneficiaries under this prospective capitation arrangement in January 1984. Final enrollment in the demonstration was 5,374, with all 1,200 cost-contract beneficiaries converting and 4,174 new members joining. They operated from six facilities. The demonstration ended on March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.:	500-82-0047
Period:	September 1982 - March 1985
Funding:	$ 730,959
Award:	Contract
Contractor:	Health Care Network, Inc. 20800 Greenfield Oak Park, Mich. 48237
Project Officer:	Ronald Deacon Division of Health Systems and Special Studies

Description: This project tested alternatives to traditional Medicare financing and delivery of health services in Detroit. Health Care Network (HCN), owned by Blue Cross of Michigan, is a group model operating in Detroit, a competitive community. HCN offered a "Medinet" program for Medicare beneficiaries through a network of 25 primary care physician groups (PPG's) composed of 8 to 25 physicians in each PPG. HCN included measures for sharing risk for the network for referral services and hospital costs. Enrollees were required to use HCN-approved hospitals.

Status: The protocol was approved in December 1983, and the demonstration became operational in January 1984. HCN was reimbursed 95 percent of the adjusted average per capita cost. The demonstration ended on March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982. Enrollment at the end of the demonstration was 2,800.

Medicare Competition Demonstration

Project No.:	500-82-0038
Period:	September 1982 - July 1986
Award:	Contract
Contractor:	Blue Cross and Blue Shield of Michigan (Blue Care) 600 Lafayette East Detroit, Mich. 48226
Project Officer:	Kathleen Farrell Division of Health Systems and Special Studies

Description: This project will test alternatives to traditional Medicare financing and delivery of health services in Detroit. The project will accept 95 percent of the adjusted average per capita cost from the Health Care Financing Administration for Medicare beneficiaries enrolled in the Detroit area. It will then contract with the Detroit Medical Center, to serve beneficiaries at favorable rates. Beneficiaries will not be locked into obtaining services through the plan; they will be allowed to seek services outside the plan provided they are willing to pay the traditional Medicare deductibles and coinsurance. This project will experiment with the concept that the financial incentives of no coinsurance or deductibles when services are received through plan providers will be sufficient to keep beneficiaries within the plan.

Status: The scheduled implementation date is January 1, 1986. Blue Care anticipates enrolling approximately 5,000 members by July 30, 1986. When the demonstration period ends, continuation will depend on compliance with the Tax Equity and Fiscal Responsibility Act of 1982 requirements.

Medicare Competition Demonstration

Project No.: 500-82-0039
Period: September 1982 - March 1985
Award: Contract
Contractor: Group Health Plan of Southeast Michigan
5700 Crook Road
Troy, Mich. 48099
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: This project tested alternatives to traditional Medicare financing and delivery of health services in Detroit. The demonstration involved a federally qualified, staff model, health maintenance organization (HMO) that has been in operation since 1977. It serves 24,000 enrollees in the Detroit area, of which 2,000 are enrolled under a Medicaid risk contract. The HMO planned to enroll 1,000 Medicare beneficiaries.

Status: The protocol for this demonstration was approved in December 1983. The demonstration became operational in February 1984. The demonstration ended on March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982. Enrollment at the end of the demonstration was 600.

Medicare Competition Demonstration

Project No.: 500-82-0040
Period: September 1982 - June 1987
Award: Contract
Contractor: Senior Health Plan
315 Iris Park Place
1885 University Avenue
Minneapolis, Minn. 55104
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: This project involves the formation and testing of a new entity, a joint venture between St. Paul-Ramsey Medical Center, Amherst H. Wilder Foundation, and Health Central, Inc. This consortium will provide comprehensive medical and institutional services to an enrolled population, and will provide benefits additional to the standard Medicare package. Extensive use of cost sharing is proposed to control utilization. The Health Care Financing Administration (HCFA) incorporated a modification to the standard adjusted average per capita cost (AAPCC) reimbursement method. Prior hospital utilization and Medicare Part B utilization are used in conjunction with current AAPCC factors to derive prospective rates for each plan member.

Status: Senior Health Plan (SHP) has completed and met all developmental requirements regarding participation as a Medicare HMO demonstration (e.g., protocol and marketing materials). SHP has received waiver and service agreement approval from HCFA and is operational. SHP will operate under a Medicare/Private Sector Membership Ratio System that will assure the plan's compliance with the membership mix (50/50) requirements of the Tax Equity and Fiscal Responsibility Act of 1982. Current Medicare enrollment is 4,500.

Medicare Competition Demonstration

Project No.: 500-82-0041
Period: September 1982 - June 1985
Award: Contract
Contractor: Affiliated Professionals, Inc.
One Parkland Boulevard
Suite 1002 West
Dearborne, Mich. 48126
Project Officer: John Sirmon
Division of Health Systems and Special Studies

Description: This project tested alternatives to traditional Medicare financing and delivery of health services in Detroit, Michigan, and three surrounding metropolitan counties. Affiliated Professionals (APRO) is a health maintenance organization (HMO) management firm. The plan provided for participation by a large teaching hospital (Henry Ford Hospital), including the hospital's outreach clinic system. APRO received payments from the Health Care Financing Administration and disbursed funds to the sites.

Status: APRO has completed and met all developmental requirements regarding participation as a Medicare HMO demonstration (e.g., protocol and marketing materials). APRO received waiver and service agreement approval from the Health Care Financing Administration. At the conclusion of the demonstration, APRO enrollment was 1,792 Medicare members and 3,500 private sector members. The demonstration ended on July 1, 1985, and converted to a standard Medicare HMO risk contract under the provisions of the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.:	500-82-0030
Period:	September 1982 - March 1985
Award:	Contract
Contractor:	American Medical Care and Review Association 5410 Grovesnor Lane Bethesda, Md. 20814
Project Officer:	Kathleen Farrell Division of Health Systems and Special Studies

Description: The purpose of this Medicare competition demonstration was to develop and test alternative models of financing and/or delivering health care for Medicare beneficiaries that enhance competition. The American Medical Care and Review Association, a trade association of individual practice association model, health maintenance organizations (HMO's), conducted a capitation demonstration to test a unique component that involved the establishment of a pooled-risk reserve to cover any losses of the HMO's. There were seven member plans. Each plan was reimbursed at 95 percent of the adjusted average per capita cost.

Status: The seven original member plans were: Health Plus (formerly Genesee Health Care) of Flint, Mich.; Central Massachusetts Health Care of Worcester, Mass.; South Florida Group Health of Miami, Fla.; Delmarva Health Care of Easton, Md.; Choicecare of Cincinnati, Ohio; Crossroads Health Plan of East Orange, N.J., and Health Ohio (formerly Marion HMO) of Marion, Ohio. At the end of the demonstration the combined enrollment for the seven plans was 21,000 Medicare beneficiaries. The demonstration ended on March 31, 1985, and most of the plans continue serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.:	500-82-0035
Period:	September 1982 - March 1985
Award:	Contract
Contractor:	Health America Corporation 3310 West End Avenue Nashville, Tenn. 37203
Project Officer:	Ronald Deacon Division of Health Systems and Special Studies

Description: This project demonstrated and tested an alternative health plan. Health America Corporation is a national health maintenance organization (HMO) management firm that owns or manages 15 HMO's. The demonstration was to be conducted at eight sites. However, because of the promulgation of the regulations implementing the Tax Equity and Fiscal Responsibility Act of 1982, only one plan became operational under the demonstration (Health America of Broward in Ft. Lauderdale, Fla.). The reimbursement was 95 percent of the adjusted average per capita cost.

Status: Health America of Broward became operational on February 1, 1983. The design phase, including protocol, waiver approval, service agreement signature, marketing, and systems changes, was completed for an effective date of February 1, 1983. More than 1,000 Medicare beneficiaries were enrolled as a result of their transfer from a Health America of Broward cost contract. As of March 1985, there were approximately 2,700 Medicare enrollees. The demonstration ended on March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 95-P-98256/2-02
Period: February 1983 - March 1985
Award: Grant
Grantee: Genesee Valley Group Health Association
Gateway Centre
150 East Main Street
Rochester, N.Y. 14647
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: Genesee Valley Group Health Association (GVGHA) is a 12-year-old federally qualified, health maintenance organization (HMO) located in Rochester, N.Y. Group Health competed for area beneficiaries by offering an expanded benefit package at a low premium with a lock-in provision. The HMO accepted 95 percent of the adjusted average per capita cost. Group Health had a cost contract and converted 1,240 of these beneficiaries into the demonstration.

Status: GVGHA's operational protocol and marketing materials were approved in September 1983. GVGHA started marketing activities in September and began offering services in December 1983. Final Medicare enrollment in the risk demonstration totaled 5,130, including a cost conversion group of 1,240. Overall enrollment in the HMO totaled 40,500. Three separate options were offered, with premiums ranging from $15.00 to $30.00 per month. The demonstration ended on March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 95-P-98340/9-02
Period: June 1983 - June 1985
Award: Grant
Grantee: French Hospital Medical Center
4131 Geary Boulevard
San Francisco, Calif. 94118
Project Officer: Ronald Deacon
Division of Health Systems and Special Studies

Description: The purpose of the project was to test a hospital-based, health maintenance organization (HMO) model designed to enhance competition in the San Francisco area and provide increased choice for Medicare beneficiaries. French accepted reimbursement at 95 percent of the adjusted average per capita cost and will offer an enriched benefit package.

Status: The project's operational protocol was approved in July 1984. An open enrollment period began in September 1984, with an October 1984 effective date. The demonstration ended on June 30, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982. Enrollment at the end of the demonstration was 3,600.

Medicare Competition Demonstration

Project No.: 95-P-98338/0-01
Period: June 1983 - June 1985
Award: Grant
Grantee: Healthcare
1800 I Street
Sacramento, Calif. 95814
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: Healthcare of Sacramento is a federally qualified, group practice model, health maintenance organization (HMO) serving 15,000 enrollees in Sacramento. The Plan has been State-certified since 1978 and currently holds a Medi-Cal contract with 5,000 enrollees. This demonstration was similar in most respects to other Medicare competition demonstrations. Healthcare enrolled beneficiaries on a voluntary basis and is being reimbursed at 95 percent of the adjusted average per capita cost. Among its goals, Healthcare planned to demonstrate that preventive health care, health promotion programs, and the delivery of health services by health care professionals other than physicians, such as physician assistants, are effective and well-received by Medicare beneficiaries.

Status: Healthcare has enrolled approximately 1,000 Medicare beneficiaries in the Sacramento area after 1 year of demonstration experience. The demonstration ended on June 30, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982.

Medicare Competition Demonstration

Project No.: 500-84-0049
Period: August 1984 - August 1989
Award: Contract
Contractor: Arizona Physicians Independent Practice Association
4041 North Central Avenue
Phoenix, Ariz. 85012
Project Officer: Ronald Deacon
Health Systems and Special Studies

Description: The purpose of this project is to test innovative alternatives to existing practices of financing and delivering health care to Medicare beneficiaries under competitive market conditions. As an independent practice association model, health maintenance organization, the demonstration will test how quality care can be provided to Medicare beneficiaries under a competitive delivery system at a reduced cost to the government (85 percent of the adjusted average per capita cost) and to the Medicare beneficiary.

Status: Arizona Physicians Independent Practice Association intends to submit an operational protocol in early 1986.

Medicare Competition Demonstration

Project No.: 500-84-0050
Period: August 1984 - August 1989
Award: Contract
Contractor: AmeriMed
303 Glenoaks Boulevard
Suite 900
Burbank, Calif. 91502
Project Officer: Eric R. Nevins
Health Systems and Special Studies

Description: The purpose of this project is to test innovative alternatives to existing practices of financing and delivering health care to Medicare beneficiaries under competitive market conditions. As a group model health maintenance organization, the demonstration will test how quality care can be provided to Medicare beneficiaries under a competitive delivery system at a reduced cost to the Government (85 percent of the adjusted average per capita cost) and to the Medicare beneficiary.

Status: The final protocol was submitted by AmeriMed in September 1985. It is anticipated that the design and development stage will be completed in time for operations to commence in 1986.

Alternate Models for Prepaid Capitation of Health Care Services for Medicare Beneficiaries--Oregon

Project No.: 500-78-0078
Period: September 1978 - March 1985
Funding: $ 1,044,160
Award: Contract
Contractor: Kaiser Foundation
Health Services Research Center
4610 Southeast Belmont Street
Portland, Oreg. 97215
Project Officer: Nancy Row
Division of Health Systems and Special Studies

Description: This prospective risk capitation, Medicare health maintenance organization demonstration tested a reimbursement methodology based on 95 percent of the adjusted average per capita cost in the Kaiser Portland/Oregon region. The savings between the capitation rate and the adjusted community rate was returned to the beneficiaries in the form of increased benefits, reduced cost sharing, or both. A variety of marketing approaches were tested.

Status: This project had 4 years of operational experience. The demonstration ended on March 31, 1985, and the plan continues serving Medicare beneficiaries under the Tax Equity and Fiscal Responsibility Act of 1982. Enrollment at the conclusion of the demonstration was approximately 8,000 Medicare beneficiaries.

Senior Group Health Plan Waiver-Only Medicare Competition Demonstration Program

Project No.:	95-C-98625/4-02
Period:	October 1984 - September 1988
Award:	Cooperative Agreement
Awardee:	Finlay Medical Centers HMO Corporation 1401 Brickell Avenue, Suite 603 Miami, Florida 33131
Project Officer:	Ronald Deacon Health Systems and Special Studies

Description: Finlay Medical Centers HMO Corporation received a waiver-only cooperative agreement award on October 1, 1984, renewable on an annual basis for 4 years. Finlay is a staff-model, health maintenance organization (HMO) that is State-qualified and has implemented a risk capitation at 85 percent of the adjusted average per capita cost in Dade and Broward Counties in Florida. Approximately 8,500 fee-for-service Medicare beneficiaries and 12,000 private enrollees are served. Finlay offers prescription drugs, eye examinations and glasses, hearing examinations and aids, and a dental plan at no premium to the Medicare enrollees.

Status: Finlay submitted its draft protocol with marketing materials in November 1984. Marketing began February 1, 1985, and enrollment began March 1, 1985, with membership reaching 1,500 Medicare beneficiaries by September 1985.

Evaluation of Health Maintenance Organization (HMO) Capitation Demonstrations

Project No.: 500-81-0017
Period: February 1981 - June 1985
Funding: $ 2,272,672
Award: Contract
Contractor: Jurgovan and Blair, Inc.
51 Monroe Street
Rockville, Md. 20850
Project Officer: Alan S. Friedlob
Division of Long-Term Care Experimentation

Description: This evaluation examines the experience of eight health maintenance organizations (HMO's) who have contracted with the Health Care Financing Administration (HCFA) under a prepaid, at-risk basis to provide services to Medicare beneficiaries. These demonstrations are the precursors of current legislation contained in the Tax Equity and Fiscal Responsibility Act of 1982, Section 114. The evaluation's objectives are:

- To measure HMO versus fee-for-service differences in utilization patterns for Medicare beneficiaries, standardizing for population differences.
- To assess the accuracy of HCFA's method of estimating what HMO enrollees would have costed under fee-for-service (that is, for the adjusted average per capita cost or AAPCC).
- To assess the cost effectiveness of different marketing methods to the Medicare beneficiary population.
- To assess the fiscal impact of the demonstrations for HCFA, for the HMO, and for beneficiaries.
- To examine the organizational changes in both the administrative and delivery systems conditioned by the addition of seniors to HMO membership.
- To analyze the implications of the demonstrations for national policy.

Status: An actuarial critique of the AAPCC was completed in April 1982. A survey of Medicare beneficiaries who joined the plans and those who chose not to enroll has been completed in Marshfield, Wis., Worcester, Mass., and Minneapolis-St. Paul, Minn. Survey findings for the Twin Cities are presented in a report entitled, Marketing Medicare in a Competitive Environment, Stock No. 017-060-00181-0, price $1.25. Reports examining rate-setting issues, the operational issues facing HMO's and competitive medical plans contemplating risk-based Medicare contracting have also been completed. The report concerning operational issues entitled, Health Maintenance Organization Risk Contracting Under Medicare, Stock No. 017-060-00163-1, price $5.50, has been published in the Grants and Contract Series. Order reports by stock number from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Evaluation of the Medicare Competition Demonstrations

Project No.:	500-83-0047
Period:	October 1983 - June 1988
Funding:	$ 3,797,219
Award:	Contract
Contractor:	Mathematica Policy Research, Inc. Suite 550 600 Maryland Avenue, SW. Washington D.C. 20024
Project Officer:	James Hadley Division of Health Systems and Special Studies

Description: The Health Care Financing Administration is sponsoring an evaluation of a major series of demonstrations, designed to introduce significant competition into the market for providing health services to Medicare beneficiaries. The evaluation focuses on 20 health maintenance organizations and other competitive medical plans (CMP's) throughout the United States that provide health services to Medicare beneficiaries for a prospectively determined payment. This evaluation focuses on the following major policy issues:

- What are the impacts of enrollment of Medicare beneficiaries by CMP's under risk-based capitation on the use, quality, and cost of care?
- What are the determinants of consumer choice of CMP's? What marketing strategies are pursued by CMP's?
- Does biased selection occur, and if so, what is its nature and extent?

Status: The evaluation began in October 1983. Reports on the implementation of the demonstrations and the decision of demonstrations to enter the market will be available December 1985. A preliminary use on cost analysis (using aggregate data), along with reports on quality assurance mechanisms in the plans, beneficiary satisfaction, and an analysis of consumer choice will be available during Spring 1986. A more detailed use and cost analysis, biased selection analysis, and process of care analysis will become available during 1987 and 1988.

Evaluation of Medicare Health Maintenance Organization Demonstration Projects

Funding: Intramural
Project Officers: Judith A. Kasper and Alan S. Friedlob
Division of Beneficiary Studies and
Division of Long-Term Care Experimentation

Description: This study evaluates demonstration projects undertaken to encourage health maintenance organizations (HMO's) to participate in the Medicare program under a risk mechanism. Three demonstration HMO's are included in the study: the Fallon Community Health Plan, the Greater Marshfield Community Health Plan, and the Kaiser-Permanente Medical Program of Portland, Oreg. The study includes 18,085 aged Medicare beneficiaries who had enrolled in the plans as of April 1981. Also included are comparison groups from a 5-percent random sample of aged Medicare beneficiaries living in the same geographic areas as the control groups. The evaluation examines issues such as biased selection, patterns of prior and post-enrollment use by HMO enrollees, and comparisons of use and expenditure patterns by HMO and non-HMO beneficiaries. The distribution of principal diagnoses and surgical procedures between enrollee and comparison groups will also be examined for the Marshfield and Fallon sites; this will provide information on enrollment selection bias as well as differences in patterns of care post-enrollment.

Status: Data files for Marshfield and Fallon will be completed by November 1985. The first report from these data will be available by the end of May 1986.

Santa Barbara Health Initiative

Project No.:	11-C-98036/9-04
Period:	September 1981 - September 1986
Funding:	$ 424,364
Award:	Cooperative Agreement
Awardee:	California Department of Health Services 714-744 P Street Sacramento, Calif. 95814
Project Officer:	Eric R. Nevins Division of Health Systems and Special Studies

Description: The Santa Barbara Health Initiative (SBHI), a county demonstration project, developed and implemented a primary care network to serve Medi-Cal eligibles residing within Santa Barbara County. The Health Authority (HA), an administrative body established by the county, has contracted with the State for administration and with providers for service delivery. The HA has signed contracts with 432 physicians, out of the 560 in the county. The Health Care Financing Administration (HCFA) and the State reimburse SBHI a prospective amount based on 95 percent of fee-for-service costs. At the county level, an account is credited for each contracting primary care physician. The HA pays physicians 80 percent of the estimated cost of services per person, with the remaining 20 percent placed into a reserve account. Out of this reserve is deducted administrative overhead, a 2-percent separate risk reserve, and any surplus which, at the end of the year, is distributed to the participating primary care physicians. Hospital payment is based on Medi-Cal experience, with prospective rates set for hospitals as all-inclusive payments per Medi-Cal hospital day. Monthly advance payments are made to hospitals calculated at 50 percent of expenditures. Eight hospitals have signed formal contracts with HA.

Status: Service delivery began on September 1, 1983, under waivers from HCFA and State-enabling legislation. Approximately 25,000 beneficiaries in the county were enrolled in the program. The demonstration is scheduled to end in September 1986. After 1 operational year, the demonstration has been successful, as the county was able to provide the full range of services to Medi-Cal beneficiaries and distribute a 3-percent surplus to its primary care physicians. However, with tightening of the Medi-Cal program, SBHI projected a future deficit at the 95-percent reimbursement rate and requested a higher rate at 98 percent. HCFA subsequently denied this increased rate for the demonstration project. The reimbursement rate for the last year of the demonstration will remain at 95 percent of the fee-for-service equivalent.

Monterey County Health Initiative

Project No.:	11-C-98035/9-04
Period:	September 1981 - March 1985
Funding:	$ 369,490
Award:	Cooperative Agreement
Awardee:	California Department of Health Services 714-744 P Street Sacramento, Calif. 95814
Project Officer:	Eric R. Nevins Division of Health Systems and Special Studies

Description: The Monterey Health Initiative (MHI), a county demonstration project, developed a primary care network to serve Medi-Cal recipients within Monterey County. The Health Authority (HA), an administrative body established by the county, contracted with the State for administration and with providers for all health services. The HA had contracts with 160 primary care physicians, out of the 200 physicians in the county, and contracts with 8 hospitals and 14 nursing homes. Service delivery began on June 1, 1983, after which all Medi-Cal beneficiaries received Medi-Cal services through the locally managed MHI. Approximately 28,000 beneficiaries in the county were enrolled in the program. The Health Care Financing Administration and the State reimbursed MHI a prospective amount based on 95 percent of fee-for-service costs. MHI established a personal account for each contracting physician. A projected sum was deposited into the account each month on behalf of each beneficiary who had chosen that physician. Claims were paid from the personal accounts of physicians at the rate of payment in effect for the California Medi-Cal program. In addition, each contracting physician received a monthly $3 case-management fee. Each month, the personal physician received, for each beneficiary in his account, a report of services rendered during the previous month.

Status: MHI experienced a deficit of approximately $5 million since it became operational in June of 1983. The State decided to terminate the demonstration in February 1985. Medicaid recipients reverted back to the fee-for-service system on March 1, 1985. To assure continuity of care for recipients, MHI reimbursed providers for care delivered during February 1985, before distributing on a prorated basis available funds to meet existing liabilities for past care. The external evaluation of MHI demonstration is being continued to determine the reasons for its difficulties and to compare the model with the relative success of the Santa Barbara Health Initiative. The probable reasons for MHI's problems are that the program included little risk for participating providers, coupled with overly generous reimbursement incentives, leaving the county with excessive risk. MHI paid the case-management fee to physicians, in addition to reimbursing on a fee-for-service basis, and was unable to establish its planned utilization-control program.

Florida Alternative Health Plan Project

Project No.:	11-C-98231/4-03
Period:	June 1982 - June 1986
Funding:	$ 729,114
Award:	Cooperative Agreement
Awardee:	State of Florida 1317 Winewood Boulevard Tallahassee, Fla. 32301
Project Officer:	Ronald Deacon Division of Health Systems and Special Studies

Description: This project is designed to demonstrate and test a number of methods for promoting competition among health care providers and insurers. The competitive models include:

- Competitive alternative health plans (competitive procurement process).
- Recipient case management (case management focused on overutilizers).
- Alternative health plan for the frail elderly (risk contracts with organizations to provide health, home, and community-based services on a prepaid basis).
- Medical care vouchers (consumer choice model utilizing nonnegotiable vouchers).

Status: Two health maintenance organizations in Dade County responded to the competitive bid model, but the State did not proceed through the procurement process because of a protest filed by one bidder. The State has decided to contract with health maintenance organizations through individual negotiation rather than competitive bidding. Three different organizational models for recipient case management are to be tested in Jacksonville, Tampa, and Orlando. One model in Tampa is operational. In June 1985, the State withdrew its Section 1115 waiver for the case-management model and will continue operation under the existing Medicaid plan. A draft protocol for the frail-elderly module was submitted in September 1985. Implementation is scheduled for January 1986. The State is not planning to submit a protocol for the voucher model.

Medicaid Voucher Demonstration

Project No.: 11-C-98223/5-03
Period: June 1982 - June 1986
Funding: $ 556,160
Award: Cooperative Agreement
Awardee: Minnesota Department of Public Welfare
2nd Floor-Space Center
444 Lafayette Road
St. Paul, Minn. 55101
Project Officer: Eric R. Nevins
Division of Health Systems and Special Studies

Description: Minnesota was awarded a grant to develop a prepaid capitation demonstration project for the eligible Medicaid population in three countries: one urban, Hennepin; one suburban, Dakota; and one rural, Itasca. For all counties, the per capita payment will be calculated based on the average fee-for-service cost per eligible in the program in each county. This rate will be paid to competing health plans who organize to provide services to Medicaid recipients within the urban and suburban counties. A rate-cell approach is being used to pay capitation rates. The cells incorporate adjustments for age, sex, category of eligibility, county of residence, and institutional and Medicare status. The capitation rate to plans for Aid to Families with Dependent Children (AFDC) recipients will be 90 percent of the fee-for-service costs, and for Supplemental Security Income (SSI) recipients, the rate will be 95 percent of the fee-for-service costs, with both rates including loss-sharing provisions with Medicaid health plans up to 100 percent of the fee-for-service costs in the worst case scenarios. As the project is intended to demonstrate the shifting of financial risk from the State and the Health Care Financing Administration (HCFA) to the Medicaid health plans, this aggregate loss sharing will be phased out over the 3-year implementation period. The demonstration plans to enroll the AFDC, Aged, Blind and Disabled, including mentally retarded and mentally ill populations, in prepaid health plan arrangements. In Hennepin County, an experimental group consisting of 35 percent of the Medicaid population will be randomly selected to participate in the project. In Dakota County, the mental health/chemical dependency portion of the rate will be broken out and paid separately to the county. The county has chosen to bear both the risk and responsibility of providing these services. The rural county will not have competing plans. The capitation will go to the county who has contracted with Health Maintenance Organization (HMO) of Minnesota for claims processing and management services. HMO Minnesota will coordinate the case management and utilization controls and supervise local providers in delivering services to the Medicaid population.

Status: The State submitted an operational protocol that was approved by HCFA in September 1985. The project began the implementation phase in Itasca County in September 1985 and will begin in Hennepin and Dakota Counties in December 1985. There are presently eight participating competing plans in the Hennepin County model.

Arizona Health Care Cost-Containment System

Project No.: 11-P-98239/9-03
Period: June 1982 - June 1987
Award: Grant
Grantee: AHCCCS Administration
124 West Thomas
Phoenix, Ariz. 85013
Project Officer: Sidney Trieger
Division of Health Systems and Special Studies

Description: This project is designed to test the effectiveness of establishing under the Social Security Act, Title XIX, a Medicaid program based on competitive principles, including primary care physicians acting as gatekeepers, prepaid capitated contracts, competitive bidding, the use of nominal copayments, limited restrictions on freedom of choice, and capitated payment by the Health Care Financing Administration (HCFA). The Arizona Health Care Cost-Containment System (AHCCCS) was implemented October 1, 1982, as a 3-year demonstration.

Status: The State was granted a 2-year extension to the AHCCCS demonstration on July 29, 1985. During the fourth year, the capitation rate methodology was changed and will be set at the lower of either 95 percent of the estimated actuarial fee-for-service costs or HCFA's payment for the third year inflated by an appropriate factor. On August 12, 1985, the State announced that it had awarded contracts to 20 prepaid health plans for the fourth year of the AHCCCS demonstration beginning on October 1, 1985. An open enrollment period was held from August 19, 1985, to September 1, 1985, to allow recipients to change plans.

Evaluation of the Arizona Health Care Cost-Containment System

Project No.: 500-83-0027
Period: June 1983 - September 1986
Funding: $ 2,489,488
Award: Contract
Contractor: SRI International, Inc.
333 Ravenswood Avenue
Menlo Park, Calif. 94025
Project Officer: Paul Lichtenstein
Division of Health Systems and Special Studies

Description: This project will evaluate the implementation, operation, and impact of the Arizona Health Care Cost-Containment System (AHCCCS), which is a unique and innovative State-sponsored demonstration that provides public assistance medical care (medical assistance) to residents of Arizona who are eligible for Aid to Families with Dependent Children and Supplemental Security Income cash payments. The study will focus on measuring the effects of AHCCCS on cost, quality, and utilization of health care as well as issues related to patient access and satisfaction. The following major innovative cost-containment methods, which are unique to Arizona among all State Medicaid Programs, will be evaluated:

- Capitation prepayment contracts, awarded as a result of competitive bidding, to health care plans that provide or arrange for the provision of covered services.
- "Gatekeeping" by a primary care physician who will be responsible for either providing or authorizing the services to be reimbursed for the enrollees, including any services provided by specialists.
- Use of nominal copayments as a means of inhibiting unnecessary utilization.
- Restriction on freedom of choice of plans and providers.
- Capitated payment of Federal financial participation by the Health Care Financing Administration to the State of Arizona based on the number of enrollees.

Status: To date, SRI has produced the following documents:

- A literature review on the major study topics and the methodologies for their evaluation.
- An evaluation plan that details the issues to be addressed by the study and the methodological approaches to be utilized.
- A case study which describes the events that occurred during the first 18 months of the AHCCCS program operation.

Missouri Medicaid Prepaid Health Demonstration Project

Project No.:	11-C-98225/7-04
Period:	June 1982 - June 1986
Funding:	$ 393,917
Award:	Cooperative Agreement
Awardee:	Missouri Department of Social Services P.O. Box 88 Jefferson City, Mo. 65103
Project Officer:	Eric R. Nevins Division of Health Systems and Special Studies

Description: Missouri has implemented a citywide consumer choice model characterized by the use of various incentives, different marketing techniques, and the offering of a range of alternative health plans (AHP's). Missouri mandatorily enrolled approximately 23,000 Aid to Families with Dependent Children (AFDC) eligibles in the Kansas City area under five AHP contracts or contracting physician sponsors. The project incorporates many of the components of competitive systems, including: consumer choice among AHP's; risk-sharing based on capitated reimbursements; a variety of marketing incentives; and participation of a range of organizational types. All participating plans offer at least the mandatory minimum benefit package for the categorically needy under the prepaid arrangement. Enrollment is limited to the AFDC population. Marketing has taken place in the welfare offices, focusing on a slide presentation and standardized written materials. The data to be collected under the demonstration include: site-specific utilization data; State fee-for-service utilization and expenditure data (already collected monthly under the State Medicaid Management Information System; consumer awareness and satisfaction data (collected through recipient surveys). Missouri has set its base rate of payment to AHP's at approximately 90 percent of fee-for-service costs. The base rate is augmented approximately 5 percent through risk-reduction mechanisms.

Status: The State has contracts with 5 prepaid health plans and 57 physician sponsors to participate in the program. The plans include Swope Parkway Comprehensive and Mental Health Center, Total Health Care/Prevention Plus, Truman Medical Center, University of Health Sciences, and Wayne Miner Health Center, Inc. The providers started delivering services on January 5, 1984, and the first payment under the managed health care program was made on January 20, 1984. Enrollment, as of June 30, 1985, was approximately 23,000. About 85 percent of the enrollees are in prepaid plans and 15 percent in the physician-sponsor program. There are approximately 27,500 AFDC eligibles in Jackson County; therefore, 4,500 eligibles still remain to be enrolled.

Statewide Medicaid Competition Demonstration

Project No.:	11-C-98222/2-04
Period:	June 1982 - June 1986
Funding:	$ 792,552
Award:	Cooperative Agreement
Awardee:	New Jersey Department of Human Services 324 East State Street Trenton, N.J. 08625
Project Officer:	Eric R. Nevins Division of Health Systems and Special Studies

Description: The demonstration involves implementation of a broker/case manager model. It allows, on a voluntary participation basis for Medicaid eligibles and providers, eligibles to select a provider as a case manager for 6-month intervals. These managers are responsible for all direct primary care delivery, referrals, and ancillary services for noninstitutional recipients. Case managers are reimbursed on a capitation basis and are at risk for all noninstitutional services. Capitation rates are adjusted for county of residence, sex, age, and eligibility category of the enrolled eligibles. The State had contracts with the area Professional Standards Review Organizations (PSRO's), which acted as broker organizations. The PSRO enrolled case managers and eligibles and was responsible for marketing, grievance systems, and quality-of-care monitoring. These duties have since reverted to the State. Participating eligibles select their case managers from a list provided by the broker and remain enrolled with the selected case manager for 6 months. Eligibles are, however, able to change their case managers in the first month. Providers must be directly or indirectly accessible on a 24-hour basis. The other principle subcontract was with LaJolla Management Corporation to provide assistance in major areas of developmental work, such as design of the Medicaid Management Information System and the quality-assurance system.

Status: The plan was originally to be phased-in throughout the State. Phase I implemented only the ambulatory services component and occurred in three northern, rural counties in the second year of the demonstration, from July 1, 1983, to June 30, 1984. Enrollment during this phase was minimal, as there were less than 50 current enrollees in these counties. Phase II implemented both the ambulatory and inpatient components in five additional counties and the inpatient component in Phase I counties. This phase occurred between July 1, 1984, and June 30, 1985. Enrollment during this phase was more successful, as approximately 5,000 were enrolled. The out-of-phase project, referred to as the pilot county phase, began on December 1, 1984, in three counties: Essex, Passaic, and Union. New Jersey was not prepared to go into these large counties full scale; the pilot project allowed the State to test the market area and develop systems with the County Welfare Agency on a smaller scale. The pilot gave the State a better idea of how the plan would operate in these high Medicaid areas once the demonstration was fully implemented. The State has presently enrolled 4,500 enrollees in these pilot counties, and expects to enroll an additional 12,000 in the fourth year.

Monroe County MediCap Plan

Project No.:	11-C-98230/2-03
Period:	June 1982 - August 1986
Funding:	$ 700,322
Award:	Cooperative Agreement
Awardee:	New York Department of Social Services 40 North Pearl Street Albany, N.Y. 12243
Project Officer:	Nancy Row Division of Health Systems and Special Studies

Description: Monroe County and New York State are participating in a reimbursement demonstration involving a prepaid capitated rate for Medicaid clients involved in the MediCap plan. All clients are required to select a provider from a large set of providers who have arranged to provide services through Rochester Health Network, a health maintenance organization (HMO). Initially, MediCap will enroll the Aid to Families with Dependent Children (AFDC) and home relief population (38,000) and then phase in the medical assistance and foster care eligibles (7,500). Supplemental Security Income is the last group of eligibles to be phased in. After 6 months of implementation, MediCap expects to involve other area HMO's. The county is reimbursed a capitated rate equal to 95 percent of fee-for-service costs. The county has, in turn, developed rates for categories of eligibles which it pays Rochester Health Network.

Status: This project began enrollment in July 1985. As of October, 16,000 AFDC and home relief eligibles had been enrolled, with the remaining enrollment in this category to be completed by Spring 1986.

Competitive Managed Health Plans for AFDC Medicaid Recipients

Project No.: 11-P-98330/1-02
Period: March 1983 - June 1986
Award: Grant
Grantee: Massachusetts Department of Public Welfare
600 Washington Street
Boston, Mass. 02111
Project Officer: Marla Aron
Division of Health Systems and Special Studies

Description: This project is designed to demonstrate and evaluate five models of "managed health care," developed by the Massachusetts Medicaid program for recipients of Aid to Families with Dependent Children (AFDC), in terms of cost, utilization, consumer satisfaction, administration, and quality of care. The five models are: case management, health maintenance organizations (HMO's), ambulatory capitation, capitated dental program, and fiscal intermediary.

Status: All five models were tested during the second grant year. The case-management model serves approximately 5,000 recipients, the HMO's serve approximately 3,000 recipients, the ambulatory-capitation model serves approximately 1,000 recipients, the dental-capitation model serves approximately 1,000 recipients and the fiscal intermediary model serves approximately 400 recipients. A 6-month guaranteed eligibility and a cash incentive for recipient participation will be tested during the third grant year. Different marketing strategies for increasing provider and recipient participation are being evaluated.

Evaluation of the Medicaid Competition Demonstrations

Project No.: 500-83-0050
Period: September 1983 - September 1987
Funding: $ 3,098,938
Award: Contract
Contractor: Research Triangle Institute
P.O. Box 12194
Research Triangle Park, N.C. 27709
Project Officer: Spike Duzor
Division of Health Systems and Special Studies

Description: The Medicaid demonstrations are being implemented in six States (California, Florida, Minnesota, Missouri, New Jersey, and New York) to enhance the role of competition in the delivery of publicly financed Medicaid services. The evaluation is designed to describe and analyze the separate demonstrations, as well as to conduct a comparative impact analysis across the projects. A series of case studies and analytical reports will be done, highlighting the impact of the demonstrations' cost-containment modalities and their subsequent effect on quality of care, patient utilization, and patient satisfaction.

Status: Detailed case studies highlighting the status of each demonstration are currently available. A finalized research design, a data collection plan, and primary data collection instruments are also available. Second-year case studies and a detailed description of the rate-setting process for the operational States will be completed by Winter 1986.

Health Maintenance Organization Studies

Adjusted Average Per Capita Cost

Funding:	Brandeis University Health Policy Research Consortium (See page 184)
Project Officer:	James Lubitz Division of Beneficiary Studies

Description: The Brandeis University Health Policy Research Consortium, as part of its grant, is studying ways to improve the current adjusted average per capita cost (AAPCC). The work has been focused on four areas:

- The use of prior utilization to predict future utilization.
- The use of indicators of disability in the AAPCC.
- Analysis of risk sharing and reinsurance for Medicare health maintenance organizations (HMO's).
- Geographic variations in the AAPCC.

Status: Prior utilization--Results indicate that prior utilization is a significant predictor of future utilization. The predictive power is improved when prior hospital stays are classified into those for self-limiting conditions and those for conditions, like cancer, indicative of chronic, recurring problems. Work is continuing to refine an AAPCC model incorporating diagnostic information on prior hospital stays. Preliminary results are contained in "Prediction of Subsequent Year Reimbursement Using the Medicare History File" by Jennifer Anderson and Abby Resnick, Brandeis University Health Policy Consortium, Discussion Paper, May 1982.

Disability level--Results indicate that disability level is a significant predictor of health care use. A disability level factor, therefore, would theoretically improve the current AAPCC. However, any improvement would have to be weighed against the cost and administrative burden of acquiring disability data on Medicare enrollees. A discussion of a possible disability adjustment is contained in two draft papers from the Consortium by Leonard Gruenberg and Neil Stuart, "A Health Status-Based AAPCC: The Disability Level Based Approach," and "The Use of Disability Status as a Health Status Measure for Updating a Prior Utilization Reimbursement Model."

Reinsurance—Preliminary work has been completed on a number of reinsurance models. Brandeis is now working on plans to test modifications to the AAPCC based on their research in a number of demonstration projects.

Geographic variations—Work has just begun in this area.

An Analysis of Long-Run Rate-Setting Strategies for Risk-Based Contracting Under Medicare

Project No.: 18-C-98737/3-01
Period: September 1985 - September 1987
Funding: $ 360,081
Award: Cooperative Agreement
Awardee: Virginia Commonwealth University
1012 East Marshall Street
Richmond, Va. 23298-0001
Project Officer: James Beebe
Division of Beneficiary Studies

Description: This study will develop a model of the Medicare market as a submarket interacting with the entire market for health services to study geographic variation in the adjusted average per capita cost (AAPCC). The model will be used to analyze four different payment strategies for captitation under Medicare:

- Competitive bidding. The study will look at the feasibility of conducting competitive bidding in different geographic areas.
- Vouchers. What are the cost implications of different voucher schemes?
- Blended sector rates. How can health maintenance organization (HMO) payment rates be set in areas of high HMO penetration?
- Rates tied to non-Medicare prices.

An anlysis will be conducted to determine if Medicare payment rates can be related to the health market as a whole.

Status: The award was made in September 1985, and the project is in the early developmental stage.

Determination of Health Maintenance Organization Capitation Rates for Medicare Beneficiaries

Project No.:	18-P-98804/9-01
Period:	September 1985 - September 1988
Funding:	$ 972,467
Award:	Grant
Grantee:	Kaiser Foundation Research Institute 3505 Broadway, Suite 1112 Oakland, Calif. 94611
Project Officer:	Gerald Riley Division of Beneficiary Studies

Description: The project investigates the issues of biased selection into health maintenance organizations (HMO's) and the problem of developing a risk-adjustment methodology for HMO payments by using both internal Kaiser data and data from the Medicare Statistical system. The investigator's specific aims are as follows:

- To predict health care costs for groups of stayers and switchers in fee for service (FFS) and HMO (Kaiser), and to estimate the degree of selection bias, if any, among HMO enrollees.
- To simulate Medicare capitation rates for an HMO using alternative risk-adjustment methods and compare them with the current adjusted average per capita cost rate.
- To develop and test a risk-adjustment methodology employing cause-specific mortality and hospital morbidity for predicting aggregate use of medical care services in future years by Medicare beneficiaries enrolled in an HMO.
- To examine the implications of a separate reinsurance program for case-specific expenses above a specified level of alternative risk-adjusted capitation methods.
- To develop a risk-adjustment methodology by using ambulatory morbidity and self-perceived health status for predicting future aggregate use of medical care services by Medicare beneficiaries enrolled in an HMO.

Status: The award was made in September 1985, and the project is in the early developmental stage.

Former Disability as an Adjustment Factor for the Adjusted Average Per Capita Cost

Funding: Intramural
Project Director: Gerald Riley, Division of Beneficiary Studies

Description: Medicare data show that approximately 8 percent of Medicare beneficiaries 65-69 years of age were formerly entitled to Medicare because of disability. These beneficiaries tend to incur nearly twice as much reimbursement as other beneficiaries their age. Consequently, the Office of Research will develop and test an additional factor for the adjusted average per capita cost (AAPCC) that will adjust for previous receipt of Social Security disability benefits among aged enrollees. Included in the study will be beneficiaries who were formerly entitled to disability benefits under Social Security, but were never Medicare entitled.

Status: The Social Security Administration has provided updated information on former receipt of disability benefits for a sample of Medicare beneficiaries. This information is being linked to data from the Continuous Medicare History File. It is anticipated that results of the study will be available in 1986.

Medicare Reimbursement Regression to the Mean

Funding: Intramural
Project Director: James Beebe, Division of Beneficiary Studies

Description: Several recent studies have shown that persons who join health maintenance organizations (HMO's) tend to be lower users of health care services prior to joining than the general population. This suggests that they may be healthier. If so, the current payment method will overpay HMO's. Critics of the studies claim that the problem is overstated because any group of high or low users will become average users (regress to the mean) over a period of time. This study is intended to measure the extent to which high- and low-use Medicare beneficiaries regress to the mean and to explore whether these measures can be useful in setting capitation payments for HMO's.

Status: Data files have been formed and analysis is nearly completed. A draft paper has been prepared. Preliminary results show a variety of patterns of regression to the mean, each with different implications for HMO payment.

Medicare Health Maintenance Organization Additional Benefits

Funding: Intramural
Project Director: Judith Sangl
Division of Reimbursement and Economic Studies

Description: Section 114 of Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982, requires that, to the extent a health maintenance organization's (HMO) Medicare payment exceeds its adjusted community rate under a risk-sharing contract, the HMO must use the savings to provide its Medicare members additional benefits or reduced cost sharing. Section 114 also requires that the Secretary of the Department of Health and Human Services conduct a study of the additional benefits provided under this provision. This study will report on the number of HMO's subject to the additional benefits requirement, and the nature of the benefits that HMO's choose to provide.

Status: The study depends on data that will be collected in 1986. This information will be compiled in a report due to Congress in early 1987.

Evaluation of Prepaid Risk-Bearing Care Organizations

Funding: Intramural
Project: Gerald S. Adler
Director: Division of Beneficiary Studies

Description: This project is a preliminary analysis of policy issues and data sources with regard to health maintenance organizations and similar arrangements for care as they affect the development of Health Care Financing Administration programs. A series of evaluation options will be developed to guide further evaluative work.

Status: The project is currently in the initial stages of planning and issue development.

Social Health Maintenance Organizations

Social Health Maintenance Organization Project for Long-Term Care

Project No.:	18-C-97604/1-05
Period:	March 1980 - May 1986
Funding:	$ 1,553,478
Award:	Cooperative Agreement
Awardee:	Brandeis University Health Policy Center 415 South Street Waltham, Mass. 02254
Project Officers:	Thomas M. Kickham and Sidney Trieger Divisions of Long-Term Care Experimentation and Health Systems and Special Studies

Description: In accordance with the Congressional mandate (Public Law 98-369, Section 2355), this project developed and is currently implementing the concept of a social health maintenance organization (S/HMO) for long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed annual prepaid capitation sum.

Status: Four S/HMO demonstration sites have been selected by the Health Policy Center. These sites include two HMO types that add long-term care services to their service packages, and two long-term care providers that add acute care services to their service packages. The center and the sites have developed a common service package, financing plans, and risk-sharing arrangements. The demonstration utilizes Medicare and Medicaid waivers.

All four sites had initiated service delivery by March 1985. In the first year the sites will build enrollment levels to the projected goal of 4,000 enrollees per site. The S/HMO sites are:

- Elderplan Inc.
  Sponsor: Metropolitan Jewish Geriatric Center
  Brooklyn, New York
  Project Officer: William D. Clark

- Seniors Plus
  Sponsors: Group Health Inc. and Ebenezer Society
  Minneapolis, Minnesota
  Project Officer: John Sirmon

- Medicare Plus II
  Sponsor: Kaiser-Permanente Medical Care Program
  Portland, Oregon
  Project Officer: John Sirmon

- Senior Care Action Network Health Plan
  Sponsor: Senior Care Action Network
  Long Beach, California
  Project Officer: William D. Clark

Evaluation of Social Health Maintenance Organization Demonstrations

Project No.: 500-85-0042
Period: September 1985 - December 1989
Funding: $ 2,388,622
Award: Contract
Contractor: University of California, San Francisco
Aging Health Policy Center
San Francisco, Calif. 94143
Project Officer: Alan S. Friedlob
Division of Long-Term Care Experimentation

Description: The social health maintenance organization (S/HMO) seeks to enroll voluntarily, persons 65 years of age or over in an innovative prepaid program that integrates medical, social, and long-term care delivery systems. The S/HMO merges the health maintenance organization concepts of capitation financing and provider risk-sharing developed by the Health Care Financing Administration (HCFA) under its Medicare capitation and competition demonstrations with the case-management and support services concepts underlying Department of Health and Human Services' (DHHS) sponsored long-term care demonstrations serving the chronically ill aged. Evaluation results will be transmitted to Congress (mandated by Public Law 98-369) and will be used by HCFA and DHHS to assess whether the S/HMO concept should be fostered through changes in prepaid Medicare contracting regulations.

Status: This contract was awarded in September 1985. Interim results will be available in Spring 1987.

Other Alternative Payment Systems

California State Copayment Project

Project No.: 11-P-98206/9-03
Period: March 1982 - March 1985
Award: Grant
Grantee: California Department of Health Services
714-744 P Street
Sacramento, Calif. 95814
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: The purpose of this project is to determine if nominal copayments will reduce inappropriate use of health services without affecting needed services. Copayments are limited to ambulatory services and are collected by the provider. Early and Periodic Screening, Diagnosis, and Treatment eligibles and Medicare beneficiaries are exempt from all copayments. Copayments are, with some exceptions: $1 for each outpatient clinic or physician-type visit; $5 for each visit for nonemergency services received in an emergency room; and $1 for each drug prescription.

Status: The waivers for this demonstration ended on March 9, 1985. The draft final report was received from the State on July 9, 1985, and is currently being reviewed.

Health Care Plus: The Lutheran Medical Center Program for Prepaid Managed Health Care

Project No.: 11-P-98716/2-01
Period: August 1985 - July 1988
Award: Grant
Grantee: New York State Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: This is 1 of 13 program sites funded under the Robert Wood Johnson Foundation/Health Care Financing Administration Program for Prepaid Managed Health Care. The program is cosponsored by the National Governors' Association. It is designed to enable medical institutions, working with State and Federal Governments and private health insurers, to develop more efficient arrangements for the financing and delivery of health services. This is a Medicaid project that will utilize prospective payment and case management, and will offer 6 months of guaranteed eligibility as a participation incentive. The Lutheran Medical Center is a teaching hospital that serves the residents of the Sunset Park neighborhood of Southwest Brooklyn, N.Y.

Status: The first-year award letter for this potential 3-year, waiver-only project was sent in July 1985. The State is currently in the process of responding to the special terms and conditions of the award. The waivers are scheduled to be implemented by January 1986. The Lutheran Medical Center plans to participate in the partial randomization evaluation design that is being conducted by the Rand Corporation.

Program for Prepaid Managed Health Care

Project No.: 11-P-98715/3-01
Period: August 1985 - July 1988
Award: Grant
Grantee: Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Md. 21201
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: This project contains 2 of the 13 program sites funded under the Robert Wood Johnson Foundation/Health Care Financing Administration Program for Prepaid Managed Health Care. The program is cosponsored by the National Governors' Association. It is designed to enable medical institutions, working with State and Federal Governments and private health insurers, to develop more efficient arrangements for the financing and delivery of health services. This is a Medicaid project that will utilize prospective payment and case management, and will offer 12 months of guaranteed eligibility as a participation incentive. The two sites are the Chesapeake Health Plan and The Johns Hopkins Health Plan, both in Baltimore, Md.

Status: The first-year award letter for this potential 3-year, waiver-only project was sent in July 1985. The State is currently in the process of responding to the special terms and conditions of the award. The waivers are scheduled to be implemented by January 1986. It is anticipated that both the Chesapeake Health Plan and The Johns Hopkins Health Plan may participate in the partial randomization evaluation design that is being conducted by the Rand Corporation.

Evaluation of the Prepaid Managed Health Care Demonstration

Project No.: 99-C-98489/9-02
Period: September 1985 - April 1989
Funding: $ 2,011,265
Award: Cooperative Agreement
Awardee: The Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: Spike Duzor
Division of Health Systems and Special Studies

Description: The Rand/University of California, Los Angeles, Health Financing Policy Center will conduct an independent evaluation of the cost effectiveness of the prepaid managed health care demonstration. This demonstration project is being conducted jointly by the Robert Wood Johnson Foundation, The National Governors' Association, and the Health Care Financing Administration (HCFA). The demonstration is designed to enable health care providers to develop more efficient arrangements for the financing and delivery of health services. Most projects will be limited to Medicaid and will utilize prospective payment and case management.

Status: The evaluation activities began in September 1985, and HCFA will receive a final evaluation design and study sites selection criteria by January 1986.

PROGRAM ANALYSIS AND EVALUATION

National Medical Care Utilization and Expenditure Survey

Analysis of NMCUES Data

Project No.:	500-81-0047
Period:	September 1981 - November 1985
Funding:	$ 4,698,452
Award:	Contract
Contractor:	Research Triangle Park Institute P.O. Box 12194 Research Triangle Park, N.C. 27709
Project Officer:	Herbert A. Silverman Division of Program Studies

Description: This project involves the analysis of data (tabulations, models, and data file production) and the publication of reports based on the National Medical Care Utilization and Expenditure Survey (NMCUES). This survey was cosponsored by the Office of Research and Demonstrations, Health Care Financing Administration, and the National Center for Health Statistics, Public Health Service. NMCUES was used to collect detailed sociodemographic, health status, health insurance, and health care payment data that were not available from either the Medicare or Medicaid administrative record systems. Data were obtained from three survey components:

- A randomly selected national household sample (HHS) of the civilian noninstitutionalized population.
- Randomly selected State Medicaid household samples (SMHS) of the civilian noninstitutionalized Medicaid population in four States: California, Michigan, Texas, and New York.
- A Medicare and Medicaid administrative records survey (ARS) linked to HHS and SMHS Medicare and Medicaid respondents.

The survey was designed to produce data that would permit analysis of factors affecting the use and cost of health care services. Particular attention was given to the effects of health status, insurance coverage, out-of-pocket expenditures, and the differences in Medicaid eligibility criteria and benefit structure on the patterns of use and expenditures by program beneficiaries.

Status: The contract is now in its report production phase. Reports have been developed that analyze the relationship of utilization to health insurance coverage, out-of-pocket expenditures, access to health care, and Medicaid use by social and ethnic groups. The reports are being disseminated as they become available. A list of completed reports can be made available upon request.

Perspectives on Health Care from National Medical Care Utilization and Expenditure Survey: United States, 1980

Funding: Intramural
Project Officer: Judith A. Kasper
Division of Beneficiary Studies

Description: The purpose of this project is to develop an overview report of major findings from the National Medical Care Utilization and Expenditure Survey. Data for the Nation and the Medicare and Medicaid populations will be presented, covering sociodemographic characteristics, access to primary care, and use and expenditures for all types of health services.

Status: Completion of the report is expected by Summer 1986.

Title XIX Data Development

Acquisition and Analysis of State Medicaid Data

Project No.:	500-81-0030
Period:	June 1981 - June 1985
Funding:	$ 2,142,382
Award:	Contract
Contractor:	SysteMetrics, Inc. 4733 Bethesda Avenue Suite 600 Bethesda, Md. 20814
Project Officer:	David K. Baugh Division of Program Studies

Description: This project has acquired person-level data on Medicaid enrollment, claims, and providers from State Medicaid Management Information Systems (MMIS). Uniform files are being created to compare State trends. Data collection includes five States (California, Georgia, Michigan, New York, and Tennessee) for 1980 through 1982. These data are being used to support a number of program activities including:

- Analysis of refugee health and expenditures.
- A study of high-cost infants.
- Analysis and evaluation for selected demonstration projects.
- A series of Medicaid analytic notes.
- The Medicaid program evaluation.

These data are also being linked to Medicare records to produce information on issues related to enrollees of both Medicaid and Medicare programs.

Status: Through Spring 1985, person-level enrollment, claims, and provider data were obtained from State MMIS. System documentation was reviewed and code maps were produced to translate raw data into "uniform" files. Initial data processing and "early return" tabulations were completed for California, Michigan, and Georgia for 1980 through 1982 and for New York and Tennessee for selected time periods. A report entitled, Recipients of Covered Services Among Medicaid Enrollees: Michigan and New York, 1981, published under the Health Care Financing Notes Series, Number 3, is available from the Office of Research and Demonstrations, Publications and Information Resources Branch, Room 1-A-9 Oak Meadows Building, 6325 Security Boulevard, Baltimore, Md. 21207.

Medicaid Tape-to-Tape: Data and Analysis

Project No.:	**HCFA-500-84-0037**
Period:	**June 1984 - June 1986**
Funding:	**$ 2,132,969**
Award:	**Contract**
Contractor:	**SysteMetrics, Inc. 104 West Anapamu Street Santa Barbara, Calif. 93101**
Project Officers:	**David K. Baugh and Penelope L. Pine Division of Program Studies**

Description: This project continues the development and implementation of a Medicaid person-level data set from five State Medicaid Management Information Systems (MMIS) (California, Georgia, Michigan, New York, and Tennessee). This effort will acquire data on enrollment, claims, and providers for 1983 and 1984. These data will be used to create uniform files, provide descriptive reports, support analysis and evaluation, and develop methodology for on-line data base management. This project provides a continuum of 5 years of uniform Medicaid data for the conduct of analysis of program management, evaluation of policy alternatives, and feedback to States in the area of Medicaid financing.

Status: Currently, project staff are planning for the acquisition and processing of person-level enrollment, claims, and provider data that will be obtained from State MMIS. New "early return" tabulations will be designed to include data on mortality and diagnosis. Research is under way on a number of special topics including: Medicaid children, intermediate care services for the mentally retarded, long-term care, selected illnesses, hospital services, ambulatory services, and patterns of Medicaid utilization over time.

Study of Selected Diseases in the Medicaid Population

Project No.:	500-84-0037
Period:	September 1985 - September 1986
Funding:	$ 24,778 (partial funding)
Award:	Contract
Contractor:	SysteMetrics, Inc. 104 West Anapamu Street Santa Barbara, Calif. 93101
Project Officer:	Penelope L. Pine Division of Program Studies

Description: The Office of Research, Health Care Financing Administration, and the Centers for Disease Control, Division of Sexually Transmitted Diseases, have made an interagency agreement to provide data and analysis for specific categories of disease for the Medicaid population by using data from the Medicaid Tape-to-Tape project. The purpose of the study is to analyze Medicaid utilization, expenditures, and providers for Medicaid populations who have specific illnesses of interest, such as diabetes, accidents and injuries, and sexually transmitted diseases, and study epidemiologic patterns. One primary objective is to determine if these data can be used to study the incidence and prevalence of acquired immune deficiency syndrome (AIDS).

Status: This agreement was implemented in September 1985. The Tape-to-Tape data files are being reviewed to assess the availability of diagnosis data. Enrollment, utilization, and provider files for the specified groups of diagnoses will be created from the Tape-to-Tape data set for use in later analysis.

Section 1619 Study on the Working Disabled

Project No.:	500-84-0037
Period:	June 1985 - June 1986
Funding:	$ 52,397 (partial funding)
Award:	Contract
Contractor:	SysteMetrics, Inc. 4733 Bethesda Avenue Suite 600 Bethesda, Md. 20814
Project Officer:	David K. Baugh Division of Program Studies

Description: The Social Security Disability Reform Act of 1984 has extended the Section 1619 entitlement on a temporary basis until June 30, 1987. Section 1619 was designed as a measure to provide the working disabled the incentive of retention of their health benefits under Medicaid to allow continuation of work even after loss of some or all of their Supplemental Security Income cash benefits. The Social Security Administration (SSA) has agreed to report to Congress on the benefits of this provision to the working disabled. As part of the overall report (mandated by Public Law 98-460), the Health Care Financing Administration (HCFA) will use Medicaid Tape-to-Tape data to write one chapter of SSA's report to Congress. This chapter will describe the health utilization and expenditures for Section 1619 enrollees under Medicaid.

Status: The information HCFA will supply is being taken from an ongoing Medicaid research effort known as the Medicaid Tape-to-Tape project. This project has developed the capability of analyzing person-level data for several years in five States, New York, California, Michigan, Georgia, and Tennessee, which represent 30 percent of the total Section 1619 population. For States that are participating in Tape-to-Tape, with the possible exception of Michigan, SSA data are being matched with Tape-to-Tape data to provide Medicaid statistics for this population. In addition, HCFA is attempting to collect summary statistics from other State programs for this study. The data collected will include such information as number of inpatient hospital days and outpatient units utilized, types of service provided, and eligibility information on recipients. For these States, HCFA has been soliciting utilization and expenditure information through telephone contacts, formal data requests, and technical assistance to the Medicaid staffs.

Medicaid Tape-to-Tape Ambulatory Services Project

Funding:	Intramural
Project Director:	Benson Dutton Division of Reimbursement and Economic Studies

Description: This study seeks to provide information on Medicaid expenditures and utilization of selected ambulatory care episodes under the Aid to Families with Dependent Children category. The uniform Tape-to-Tape Medicaid data base for the States of Michigan and Georgia in 1981 and 1982 will be analyzed.

Status: A concept paper has been prepared and reviewed. Specific diagnoses have been selected for use as focal points in "tracer" analyses. Data preparation has begun. A staff paper will be prepared.

Program Management

State Medicaid Information Center Project

Project No.:	18-P-97923/3-03
Period:	January 1981 - December 1985
Funding:	$ 1,158,218
Award:	Grant
Grantee:	National Governors' Association Center for Policy Research Hall of the States Washington, D.C. 20001
Project Officer:	Aileen Pagan-Berlucchi Division of Program Studies

Description: This grant project monitors changes in State Medicaid program policy and disseminates information on these changes through a survey-based report updated every 6 months. The National Governors' Association (NGA) also contracts with research groups outside the Federal Government to produce research reports on special topics of current interest in the area. The project group at NGA works closely with State Medicaid directors and other program personnel in developing research topics and data collection priorities.

Status: The final report is expected by March 1986. Key products from this project include:

- Medicaid Survey Report: "Recent and Proposed Changes in State Medicaid Programs" from 1982 on, copublished with the Intergovernmental Health Policy Project.
- "Medicaid: Freedom of Choice" - A review of waiver applications submitted under Section 2175 of the Omnibus Budget Reconciliation Act of 1981, August 1982.
- "Volume Purchasing of Goods and Services in State Medicaid Programs," October 1982.
- "Medicaid Program Changes, State-by-State Profiles," May 1982.
- "Controlling Medicaid Costs: Second Surgical Opinion Programs," November 1982.
- "Catalog of State Medicaid Program Changes: The State Medicaid Program Information Center," December 1982.
- "Reducing Excessive Utilization of Medicaid Services: Recipient Lock-in Programs," June 1983.
- "Nursing Homes, Hospitals, and Medicaid: Reimbursement Policy Adjustments, 1981-1982," March 1983.

- "An Analysis of Responses to the Medicaid Home- and Community-Base Long-Term Care Waiver Program," June 1983.
- "Public Programs Financing Long-Term Care," January 1983.
- "Health Care Cost Containment: Proceedings of the National Governor Association Committee of Human Resources Hearing," December 1983.
- "A Review of State Task Force and Special Study Recommendations t Address Health Care to the Indigent," November 1984, copublished with th Intergovernmental Health Policy Project.
- "Medicaid Diagnosis-Related Group Hospital Reimbursement Systems: A Technical Guide for State Implementation," June 1985.

Establish and Manage a Medicaid Information and Assistance Project

Project No.: 18-C-98220/3-02
Period: September 1984 - December 1985
Funding: $ 120,000
Award: Cooperative Agreement
Awardee: American Public Welfare Association
1125 Fifteenth Street, Suite 300
Washington, D.C. 20005
Project Officer: Aileen Pagan-Berlucchi
Division of Program Studies

Description: This project is designed to analyze and make recommendations on information and assistance needs and resources from the perspective of the State Medicaid agencies. The three distinct but interrelated objectives are:

- To design, implement, and evaluate new mechanisms for matching the information and assistance needs of State Medicaid agencies with resources that are available to meet these needs.
- To continue to molitor the information and assistance needs of State Medicaid agencies, as well as the resources available to meet these needs.
- To coordinate activities with the Health Care Financing Administration and the State Medicaid Directors' Association aimed at identifying and altering problematic policies, procedures, and practices that pose as barriers to the effective administration of the Medicaid program.

Status: The final report is expected in March 1986. Key products from this project include:

- "A Directory of Information and Technical Assistance Resources for State Medicaid Agencies, 1985-86 Edition."
- Medicaid Information and Assistance Project monthly bulletin which addresses significant activities developed in: the Federal Register, court cases, and grant appeals board decisions. Forthcoming events on Medicaid-related issues are also outlined.

State Legislative Resource and Information Center on Health Care Financing

Project No.:	18-P-98266/8-02
Period:	June 1983 - December 1985
Funding:	$ 440,664
Award:	Grant
Grantee:	National Conference of State Legislatures 1125 Seventeenth Street, Suite 1500 Denver, Colo. 80202
Project Officer:	Victor McVicker Division of Hospital Experimentation

Description: This project will demonstrate that a centralized source of information on State and Federal health care financing initiatives and programs will assist the Nation's State legislatures, as well as the Health Care Financing Administration (HCFA), by contributing to a more informed decisionmaking process. A number of mechanisms will be used to establish and disseminate information from the resource center. These include surveys of State legislatures, publications, seminars, direct technical assistance, and responses to requests for specific information.

Status: As of December 31, 1985, this grant will terminate and responsibility within HCFA for this project will be transferred from the Office of Research and Demonstrations to the Office of Intergovernmental Affairs.

Intergovernmental Health Policy Project

Project No.:	18-P-98148/3-02
Period:	March 1982 - December 1985
Funding:	$ 1,305,096
Award:	Grant
Grantee:	George Washington University Rice Hall, 6th Floor Washington, D.C. 20052
Project Officer:	Aileen Pagan-Berlucchi Division of Program Studies

Description: This grant project describes current health law, policy, and legislative actions affecting State Medicaid programs. The Intergovernmental Health Policy Project (IHPP) compiles and disseminates information on State health activities, including new developments in the Medicaid cost-containment area. IHPP serves as a clearinghouse on State legislative actions. Through this clearinghouse function, IHPP distributes a monthly newsletter, "State Health Notes," detailing the current status and pending changes in the medical program. IHPP also disseminates special summaries of topical issues in the Medicaid program through the "Legislative Snapshot" report series and periodic background reports.

Status: The final report is expected by March 1986. Key products from this project include:

- Medicaid Survey Report: "Recent and Proposed Changes in State Medicaid Programs" from 1982 on, copublished with the National Governors' Association.
- "State Health Notes," a newsletter published 10 times each year.
- Background reports (for example, "Medigap: Issues and Update, 1982," "Alternatives to Institutional Care for the Elderly: An Analysis of State Initiatives," September 1981, and "Creating the Medical Marketplace: Selective Contracting in California's Medi-Cal Program, 1983."
- "Legislative Snapshot" (on such topics as nursing homes and Medicaid).
- "Focus On..."supplement to "State Health Notes," new series on special feature items within specific States.
- "DRG's and Medicaid: Recent State Actions," June 1984.
- "Status of Major State Policies Affecting Hospital Capital Investment," July 1984.
- "Mental Health Benefits Under Medicaid: A Survey of the States," January 1984.

- "A Review of State Task Force and Special Studies Recommendations t Address Health Care for the Indigent," November 1984, copublished with th State Medicaid Information Center Project.
- "Medicaid Coverage and Payment Policies on Organ Transplants, a Fift State Review," June 1985.
- "Major Changes in State Medicaid and Indigent Care Programs," July 1985.

Economic and Clinical Outcomes of Three Drug Cost-Containment Strategies in Medicaid

Project No.: 18-C-98496/1
Period: July 1984 - January 1986
Funding: $ 203,718
Award: Cooperative Agreement
Awardee: Harvard Medical School
Department of Social Medicine and Health Policy
643 Huntington Avenue
Boston, Mass. 02115
Project Officer: Penelope L. Pine
Division of Program Studies

Description: The primary objectives of this study are to determine the impact of several State cost-containment strategies on drug expenditures implemented in 1981, the use of essential versus nonessential medications, and certain clinical outcomes. The principal research activities will consist of obtaining, condensing, and analyzing drug claims and other data from Medicaid Management Information Systems of several States. The research design will involve a number of time series analyses in both study and comparison States.

Status: Three different types of Medicaid drug cost-containment strategies have been selected for study. The policy interventions and study locations are:

- Statewide limits on the number of prescriptions allowed per Medicaid patient in New Hampshire.
- Imposition of $1.00 copay for each prescribed drug in Vermont.
- Combination of strict benefit cap and copayment in Arkansas.

The project has obtained data from New Hampshire, Vermont, and Arkansas. Initial programming and analyses have been completed and aggregate data files for evaluating the impact of drug caps and copayments is under way. Also, the project has completed the development of an drug code access program. This program will allow health services researchers to reliably track or measure the use of specific drug groups in Medicaid and other health care programs in which drug utilization is recorded.

Research on Competitive Forces Driving Medicare Utilization

Project No: 17-C-98522/9-01
Period: September 1984 - September 1986
Funding: $ 241,939
Award: Cooperative Agreement
Awardee: SRI International
333 Ravenswood Avenue
Menlo Park, Calif. 94025
Project Officer: Judith Sangl
Division of Reimbursement and Economic Studies

Description: The major objective of this project is to analyze how various factors affect Medicare beneficiaries' utilization of and expenditures for services. These factors include: ownership of supplemental health insurance policies, beneficiaries' knowledge of the Medicare program and of the supplemental policies they own, and the extent for which beneficiaries are treated on assignment by physicians. Data sources include: a detailed 1982 survey of a random sample of Medicare beneficiaries in six States (California, Florida, Mississippi, New Jersey, Washington, and Wisconsin), copies of the insurance policies owned by beneficiaries in this sample, and complete Medicare utilization records for this sample from 1980 to 1982.

Status: The project has been delayed until the Medicare Automated Data Retrieval System is available for use.

The Impact of Medicaid Home and Community-Based Waiver Services for the Mentally Retarded in Maine

Project No: 11-C-98605/1-01
Period: July 1984 - January 1986
Funding: $ 48,438
Award: Cooperative Agreement
Awardee: Maine Department of Human Services
221 State Street
Augusta, Maine 04333
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: The study assesses the first year of a program which provides home-and community-based care to 200 mentally retarded persons in Maine, in lieu of institutional care. Program implementation and administration will be compared with the intended program design. Costs of services and quality of life for waiver participants will be compared with those of controls. Multiple regression will be used to estimate program effects while controlling for other characteristics of the participants and care settings.

Status: Sampling and instrumentation have been completed. Data collection and analysis are in progress.

Develop the Technology of Aide Sharing into a Transferable Form for Use by Home Health Agencies to Reduce Home Health Costs

Project No.: 17-C-98480/3-02
Period: August 1984 - July 1985
Funding: $ 109,811
Award: Cooperative Agreement
Awardee: HCR, Inc.
2121 L Street, NW.
Washington, D.C. 20036
Project Officer: Doris Sneeringer
Division of Research and Demonstrations Systems Support

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). The objective of this program is to support the development of products and services by small firms in the health care sector. This project is intended to allow HCR to explore the market potential of providing the management support services needed to develop management tools for use by home health agencies in implementing the shared-aide concept. The shared-aide concept uses a home health aide to serve several clients who reside within a restricted geographical area and whose needs for services are not continuous. Several visits in the same day to the same client could be involved. Special management techniques are needed for the recruitment and training of aides, monitoring and supervision of aides, establishing priorities and scheduling of services, and maintenance of time records for billing purposes.

Status: Phase I of this project, completed in March 1984, established the feasibility of reducing home health costs by using the shared-aide concept. Under Phase II, HCR's systems for performing job-task analysis, demand-based scheduling, aide training, recordkeeping, and accounting will be contained in an instructional manual accompanied by optional software packages. HCR began working on Phase II in October 1984. An initial draft of the programmed instruction guides for use by home health agencies and Government agencies was submitted in July 1985. The draft incorporates all elements of the shared aide system with the exception of the software program. HCR requested and was granted a no-cost extension through December 31, 1985, in order to complete and test the software program. Repeated computer hardware problems have caused a delay in completion of the testing of this package.

Self-Care Home Computer Program to Reduce Health Care Costs

Project No.:	500-85-0042
Period:	September 1985 - April 1986
Funding:	$ 25,000
Award:	Contract
Contractor:	RK Associates 405 Stanton Street Park Forest, Ill. 60466
Project Officer:	David Schwartz Division of Research and Demonstrations Systems Support

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). The major objective is to reduce the cost of medical care by increasing awareness of preventive and self-care measures by use of a proposed computer program. During Phase I, available "artifical intelligence" programs and specialized data bases will be evaluated and algorithms and flowcharts will be developed. During Phase II, the proposer will develop and evaluate the computer programs.

Status: Performance under this contract began on September 30, 1985. The project is in its early developmental stage.

Development of Staging for Six Rehabilitation Conditions and a Cross-Reference System With Their Respective Diagnosis-Related Groups

Project No.:	500-85-0043
Period:	September 1985 - April 1986
Funding:	$ 21,365
Award:	Contract
Contractor:	Brown, Jensen, and Garlaff Inc. 18 North Fourth Street, Suite 711 Minneapolis, Minn. 55401
Project Officer:	David Schwartz Division of Research and Demonstrations Systems Support

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). The project is a developmental study to define the stages of severity for six rehabilitation conditions and construct a cross-reference system for those staged conditions with their respective diagnostic groups. Physical therapists will define functional status criteria for each of the six conditions and use them as a tool to classify patients. This effort will supply the necessary content and protocol for producing and disseminating a valid teaching syllabus for the new system. This new system will allow the diagnosis-related groups (DRG's) system to better respond to the actual state of affairs in health care delivery and give health care providers a tool that will make them more responsive to the intent of DRG's.

Status: Performance under this contract began on September 30, 1985. The project is in its early developmental stage.

Consumer Health Insurance Planner for Seniors

Project No.: 500-85-0044
Period: September 1985 - April 1986
Funding: $ 24,350
Award: Contract
Contractor: Berkeley Planning Associates
3200 Adeline Street
Berkeley, Calif. 94703
Project Officer: David Schwartz
Division of Research and Demonstrations Systems Support

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). Berkeley Planning Associates proposes to develop, pretest, and market a unique consumer-oriented guidebook for the retirees and preretirees to use in planning their health care insurance coverage. The planner will employ user-friendly, example-driven techniques to explain Medicare, Medicaid, and major private supplemental health insurance coverage. Phase I will result in a detailed outline of a manual, draft protocols for surveying private insurance companies, and a draft easy-to-use worksheet to compare benefits and costs.

Status: Performance under this contract began on September 30, 1985. The project is in its early developmental stage.

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Research Centers

Brandeis University Health Policy Research Consortium

Project No.:	99-C-98526/1-02
Period:	March 1984 - May 1989
Funding:	$ 5,214,395
Award:	Cooperative Agreement
Awardee:	Brandeis University Heller Graduate School 415 South Street Waltham, Mass. 02254
Project Officer:	Henry W. Koehler Office of Research

Description: The Brandeis University Health Policy Research Consortium (HPRC) is primarily supporting the research that will be required as background for preparation of the Reports to Congress mandated in the legislation (Public Law 98-21) enacting the new Medicare prospective payment system (PPS). The Brandeis HPRC includes the Boston University School of Medicine; the Center for Health Economics Research, Cambridge, Mass.; and The Urban Institute, Washington, D.C. These institutions provide expertise in the areas of health services delivery issues, physician payment alternatives, and Medicaid and long-term care policy options, as well as microsimulation and data processing capabilities. The Brandeis Consortium is conducting research activities that will examine:

- Relative value scales.
- Variation in treatment patterns.
- The advisability and feasibility of physician DRG's and other research in support of physician reimbursement reform.
- The feasibility of eliminating separate urban and rural payment rates.
- The method under which the excluded hospitals can be paid on a prospective basis.
- The feasibility and desirability of an all-payer prospective payment system.
- The effect of Medicare PPS on State Medicaid programs.

In addition, the Brandeis Consortium is sponsoring the PPS Technical Advisory Panel which convenes quarterly to advise the Director of the Office of Research on research activities related to the mandated PPS Reports to Congress.

The Brandeis Consortium is conducting these additional activities that are not directly related to the mandated reports:

- Short-term technical assistance projects.
- Other reimbursement reform studies; in particular, the adjusted average per capita cost study.
- Analysis of health maintenance organization response to the Tax Equity and Fiscal Responsibility Act of 1982 regulations.
- Analysis of Medicaid micro data.
- Analysis of State initiatives to control expenditures of high-cost individuals.
- Selected projects for the Office of Demonstrations and Evaluations, including seven multiyear projects on demonstration issues.

Status: Each year under the cooperative agreement, the Brandeis HPRC and the Health Care Financing Administration (HCFA) jointly develop an agenda of specific topics and projects to conduct. The Center is currently in its second year of operation. To date, numerous projects have been planned or have begun on research issues related to the mandated PPS Reports and on demonstration issues. For example, the research activities on uncompensated-care costs and on sole community hospitals and rural hospitals have been incorporated in project reports submitted to HCFA.

The Rand/University of California, Los Angeles, Health Financing Policy Research Center

Project No.:	99-C-98489/9-02
Period:	March 1984 - April 1989
Funding:	$ 6,464,212
Award:	Cooperative Agreement
Awardee:	The Rand Corporation 1700 Main Street Santa Monica, Calif. 90406
Project Officer:	Thomas M. Kickham Division of Long-Term Care Experimentation

Description: The primary responsibility of the Rand/University of California, Los Angeles (UCLA) Research Center is to provide expert consultation in planning, implementing, and evaluating demonstrations and experiments in the Medicare and Medicaid programs. Among the tasks to be performed are:

- Designing a demonstration to extend the prospective payment system to posthospital services.
- Developing options papers and recommendations concerning the planning, design, and implementation of demonstrations and evaluations.
- Studying the experience of providers and patients under the New Jersey diagnosis-related group (DRG) demonstration.
- Providing technical assistance to demonstration and evaluation grantees and contractors.
- Assisting in the refinement of the Health Care Financing Administration's waiver cost estimation procedures.
- Reviewing and making recommendations on demonstrations, research or evaluation designs, and deliverables.
- Developing a framework for a Medicare vouchers demonstration.

In addition, the Center is supporting the research that will be required for preparation of the Reports to Congress mandated in the legislation (Public Law 98-21) enacting the Medicare prospective payment system (PPS). These research activities will examine:

- The impact of PPS on classes of hospitals, beneficiaries, other payers, and other providers.
- The method under which rehabilitation hospitals and units can be paid on a prospective basis.
- The advisability of the provision of cost-of-care information to public and private payers.
- Methods for evaluating the impact of PPS on the quality of medical care.

- The higher-than-anticipated increase in the experiences of the diagnostic mix in the DRG system.
- The appropriateness of outlier payments, and the applicability of severity of illness, intensity of care, or other modifications to the DRG system.
- The feasibility of an admissions volume adjustment.

Status: Each year under the cooperative agreement, the Center and the Health Care Financing Administration jointly develop an agenda of specific topics and projects to conduct. The Center is currently in its second year of operation. To date, numerous projects have been planned or have begun on demonstration and evaluation issues and on program research issues. In addition, work was compieted on the provision of cost information to public and private payers and the development of a framework to evaluate quality of care under the PPS system.

Program Analysis

Study of the Quality and Effectiveness of Experimental Fixed-Price Medicare Part A Intermediary Contracting

Project No.: 500-83-0030
Period: June 1983 - January 1985
Funding: $ 203,595
Award: Contract
Contractor: Abt Associates
55 Wheeler Street
Cambridge, Mass. 02138
Project Officer: William J. Sobaski
Division of Reimbursement and Economic Studies

Description: This project will examine the impact of experimental fixed-price contracting for intermediary services in two States, New York and Missouri. The contractor will assess the procurement processes, the transition periods, and the resultant states of readiness for operations. Analyses will be made of claims processing and program outlays, provider and beneficiary services, and the quality of audit and settlement services in the initial year of operations on a fixed-price basis. Recommendations will be provided for a methodology suitable for use in evaluating other fixed-price contracting arrangements.

Status: This project was initiated June 27, 1983. Site visits began in September 1983. Initial descriptive and analytic reports flow began in December 1983 and was continued on a bimonthly basis. The research design report was received and accepted as were preliminary reports on the procurement processes, beneficiary services impact, auditing impact, contract changes, and an evaluation methodology. The final report was submitted in April 1985. The evaluation showed that substantial savings were achieved in Missouri and modest savings in New York State. No negative impact on provider and beneficiary services was experienced in New York, while in Missouri, initial disruption of provider services were effectively resolved in the initial year of operation.

Health Services Utilization Study

Project No.: 18-P-98442/9-01
Period: September 1983 - September 1986
Funding: $ 616,268
Award: Grant
Grantee: The Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: James Lubitz
Division of Beneficiary Studies

Description: The purpose of this study is to examine whether high-use rates of certain procedures in selected geographic areas reflect inappropriate overuse and, to a lesser extent, whether low procedure rates in other areas reflect underuse. Three procedures that show large geographic variation, consume a significant amount of resources, and are likely to be overused have been selected for study from six candidate procedures. Medicare Part B claims data from 12 areas in 8 States were used to study geographic variation. A high- and low-rate area will be selected from the 12 areas for each procedure. The records of 100 physicians for each procedure in each area will be studied to determine the indications for performing each procedure. Then the indications for each procedure, as abstracted from the medical records, will be compared with the indications drawn up by an expert panel of physicians. The hypothesis is that the indications in the high-rate areas will be less generally accepted, suggesting inappropriate overuse.

Status: Work on this study is under way with additional funding from three private foundations. Medicare Part B data have been gathered and are being analyzed. Literature reviews on the indications for three procedures have been completed. Procedures chosen for study are coronary angiography, diagnostic upper gastrointestinal endoscopy, and carotid endarterectomy. Physicians have met to rank indications for five procedures, and successful pilot tests have been completed. Data gathering and processing is now under way on the indications for the study procedures.

State Medicaid Nursing Home Policies, Utilization, and Expenditures

Project No.:	18-C-98765/9
Period:	September 1985 - September 1987
Funding:	$ 156,805
Award:	Cooperative Agreement
Awardee:	University of California at San Francisco 3rd and Parnamas Avenues San Francisco, Calif. 94143
Project Officer:	Gerald S. Adler Divison of Beneficiary Studies

Description: The project will examine Medicaid long-term care use and cost across the 50 States as they are affected by State policies (utilization controls, eligibility rules, and reimbursement). Focus is on the impact of controls implemented during the period 1982-85, using annual statistical reports (HCFA Form 2082, Statistical Report on Medical Care: Recipients, Payments, and Services) for data.

Status: The project was funded in September 1985 and is in its early developmental stage.

Use of Medicare Services by Disabled Enrollees Under 65 Years of Age

Funding:	Intramural
Project Director:	James Lubitz Division of Beneficiary Studies

Description: More research has been devoted to the Medicare aged population than to the population of disabled enrollees under 65 years of age. Yet disabled enrollees comprise about 10 percent of Medicare enrollment, and Medicare expenditures for them have been rising faster than for aged enrollees. To increase knowledge of the Medicare disabled population, analyses are being carried out on patterns of health services used by the disabled. In particular, this population is being analyzed by type of disability award, i.e., disabled worker, adult disabled in childhood (ADC), or disabled spouse. Also, the aged (over 65 years of age) Medicare population who were formerly disabled Medicare beneficiaries are being studied.

Status: Results from the first study of the disabled indicate that per capita reimbursement for the disabled are equal to that of the aged and that disabled women exceed men in per capita reimbursement. The majority (82 percent) of the Medicare disabled population are disabled workers, 14 percent are adults disabled in childhood (ADC), and 4 percent are disabled spouses. Per capita reimbursement in 1978 for ADC's was considerably lower ($345) than for disabled workers ($924) or disabled spouses ($1,051). Aged Medicare beneficiaries who were formerly disabled Medicare beneficiaries have 1.9 times the per capita reimbursement of other Medicare beneficiaries in the same age group. Preliminary results also indicate that need for care, as indicated by use of Medicare services, does not diminish with time on the disability program. An article based on this study will appear in the Health Care Financing Review in 1986. A second study is being developed linking the Social Security Administration's Disability History File to Medicare records. When the link is completed, analyses will examine the relationship of such factors as reason for disability, length of time disabled, and return to work to health care use.

Use of Services by the Dually Entitled (Crossovers)

Funding: Intramural
Project Director: Alma McMillan, Division of Beneficiary Studies

Description: More than 13 percent of the aged population are covered by both Medicare and Medicaid. Two studies previously published in the Summer 1983 and Winter 1984 issues of the Health Care Financing Review, found that the dually entitled (crossovers) population differs substantially from aged persons covered by Medicare only by demographic characteristics and health service use. The dually entitled had higher per capita costs and higher mortality; they were less educated, had a poorer health status, and had lower incomes.

Status: This study on the crossovers is planned using person-level data from Medicare and Medicaid in California, New York, Georgia, and Tennessee. It will focus on patterns of long-term care and hospital use by the crossovers. The link of Medicare and Medicaid data for crossovers is nearly completed.

Studies of Medicare Use Before Death

Funding: Intramual
Project Officers: Gerald Riley and James Lubitz, Division of Beneficiary Studies

Description: These studies examine the use of Medicare services in the last years of life. This information is needed because of the large percentage of Medicare expenditures for enrollees in their last year and because of the interest in hospice care as an alternative kind of care for the terminally ill.

Status: The first study showed that 28 percent of Medicare expenditures are for persons in their last year, that persons who die receive more than six times the reimbursements of other enrollees, and that expenditures in the last year are concentrated in the last few months. The study also showed that the relative share of Medicare expenditures going to enrollees in their last year has changed little from 1967 to 1979. The results of this study were published in Health, United States, 1983, the annual report from the Secretary of the Department of Health and Human Services to the President and Congress, and in the Spring 1984 issue of the Health Care Financing Review. Knowledge gained in this study is being applied in the administration and evaluation of the hospice benefit. In addition, data on Medicare reimbursements for the dying in conventional settings will be used as comparison data to evaluate the cost and utilization experience under the new hospice benefit. A second study is under way to analyze Medicare use by cause of death. The study uses cause-of-death data from the National Center for Health Statistics linked to Medicare data. Medicare expenditures in the last year will be examined by cause of death (e.g., cancer, heart attack), type of service, and age and sex. Preliminary results indicate there is considerable variation in Medicare reimbursements in the last year of life, by cause of death. A followup study will examine patterns of Medicare use and costs for 5 years before death, by cause of death.

Post-Surgical Mortality Among the Aged for Common Operations

Funding: Intramural
Project Officer: Gerald Riley, Division of Beneficiary Studies

Description: About 2.5 million hospital stays for surgery for Medicare enrollees occur annually. Much of this surgery is to some extent discretionary. Thus, to the extent that some of these surgical procedures could be avoided, some of the associated mortality might be reduced. Using 1979-80 data, this study examines mortality up to a year after eight common operations--cholecystectomy, prostatectomy, inguinal hernia repair, cataract removal, arthroplasty of the hip (both total hip replacement and other arthroplasty), reduction of fracture of the femur, and coronary bypass--comprising about one-quarter of operations for aged Medicare enrollees.

Status: Results show that the risk of dying increases markedly with age and that patients operated on for prostatectomy and hip repair (other than total hip replacement) have higher than average mortality for up to a year following the operation. Results also show lower post-surgical mortality in the West for several operations: transurethral prostatectomy, coronary bypass, reduction of fracture of the femur, and arthroplasty of the hip (other than total hip replacement). The study provides new data on the risks of coronary bypass surgery among the elderly, showing that the risk of dying in the 1.5 months after bypass surgery is 6 percent, and that the risk is 1.7 times greater for women than men. An article based on this study was published in the Summer 1985 issue of the Health Care Financing Review.

The Relation of Surgical Volume and Other Factors to Mortality After Surgery

Funding: Intramural
Project Director: Gerald Riley, Division of Beneficiary Studies

Description: Do hospitals that do more surgeries have better outcome in terms of mortality than other hospitals? Studies of the general population have found better outcomes for some operations in hospitals with a high volume of surgeries. This study investigates whether there is such a relation in the Medicare population for 8 operations--transurethral prostatectomy; reduction of fracture of the femur; resection of intestine; cholecystectomy; repair of inguinal hernia; coronary bypass, and total and other hip repair.

Status: High surgical volumes were found to be significantly associated with lower mortality within 60 days of surgery for resection of the intestine, coronary artery bypass, transurethral prostatectomy, and arthroplasty of the hip (other than total replacement). For the other four procedures, no relationship was found between surgical volume and mortality. The analyses were repeated using in-hospital deaths instead of death within 60 days of surgery as the dependent variable, and the results indicated a considerably stronger association between volume and mortality. An article based on this study was published in the Fall 1985 issue of the Health Care Financing Review.

Rehospitalization After Surgery Among Medicare Enrollees

Funding: Intramural
Project Director: Gerald Riley, Division of Beneficiary Studies

Description: This study examines patterns of rehospitalization for Medicare enrollees after seven common operations. Patterns of rehospitalization by age, sex, type of hospital, and time after operation (up to 9 months) will be investigated. Diagnoses and procedures associated with rehospitalization will be described.

Status: Preliminary results show considerable variation among procedures with respect to rehospitalization within both 7 days and 30 days following discharge from the surgical stay. Rehospitalization rates following surgery were higher than the average for the Medicare population for all seven procedures, for at least 9 months following surgery. Regional patterns were also evident, with lower rates of rehospitalization in the Northeast and higher rates in the South.

Study of High-Cost Infants Under Medicaid

Funding: Intramural
Project Director: Gerald Riley, Division of Beneficiary Studies

Description: This study will focus on infants who incur high levels of reimbursements under the Medicaid program. Michigan data for 1980 and 1981 from the Health Care Financing Administration's Tape-to-Tape project will be used. The study will focus on costs, diagnoses, services, incidence (in Medicaid), and mortality rate for such infants.

Status: Extensive data processing activities are still being implemented. Preliminary data indicate that, in 1981, there were about 500 hospitalizations for premature births in Michigan, with average hospital costs of about $11,000.

Changes in the Distribution of Medicare Expenditures

Funding: Intramural
Project Director: Gerald Riley
Division of Beneficiary Studies

Description: A large portion of Medicare expenditures has historically been concentrated on a small number of beneficiaries who are heavy users of services. The question often arises as to whether expenditures under the program have become more or less concentrated over time among small numbers of high-cost individuals. This study will compare distributions of Medicare reimbursements for 1969, 1975, and 1982. The data will be analyzed for persons dying and for survivors in 1975 and 1982. The distribution of 1980 expenditures for the non-Medicare population, as reported in the National Medical Care Expenditure and Utilization Survey, will also be examined.

Status: Preliminary data indicate that Medicare reimbursements have become slightly less concentrated among all enrollees in recent years. The concentration of expenditures was much greater among survivors than among people who died in 1975 and 1982, with little change in the distribution of expenditures within either group. An article is scheduled to appear in the Spring 1986 issue of the Health Care Financing Review.

Medicare and Medicaid Data Book

Funding: Intramural
Project Directors: Martin Ruther and Aileen Pagan-Berlucchi
Division of Program Studies

Description: This report provides descriptive statistics on the organization and operation of the Medicare and Medicaid programs. It compares the two programs' beneficiary charactertistics, use of medical services, expenditures, financing, and administration. The 1984 edition will include a new two-part section describing Medicare policy as applied to the control of hospital care costs and analyzing changes in the factors that determine Medicaid expenditures. The report includes appendixes that provide sources of information contained in the book and names and addresses of program officials. This report provides a resource for public officials, researchers, policy analysts, and users and providers of health care.

Status: The Medicare and Medicaid Data Book, 1983 has been published and is available only from the National Technical Information Service, accession number PB85-230464/AS. The 1984 edition is projected to be published in Winter 1986; it will be available from the Superintendent of Documents, U.S. Government Printing Office.

Program Statistics Series Reports and Health Care Financing Notes

Funding: Intramural
Project Directors: Charles Helbing and Martin Ruther
Division of Program Studies

Description: These statistical reports and notes describe, measure, and evaluate Medicare program benefits, program initiatives, program operation, and performance. The annual Medicare benefit reports are mandated by the Social Security Law. The other program reports and notes are either directly mandated by Congress, reflect current topical issues of the day, or reflect current legislative and/or policy initiatives and directives.

Status: The following Health Care Financing Notes and Research Briefs have either been recently completed or have been sufficiently developed so that usable data are available upon request:

- "Medicare: Inpatient Use of Short Stay Hospitals, 1983."
- "Hospital Outpatient Services Under Medicare, Trends and Demographic Variations, 1983."
- "Medicare: Use and Charges for Inpatient Services in Short-Stay Hospitals, by Diagnosis-Related Groups, Calendar Years 1981 and 1984."
- "Medicare: Surgical Procedures in Short-Stay Hospitals, by Census Region, 1983."
- "Medicare: Participating Providers and Suppliers of Service, December 1985."
- "Medicare: Use and Cost of Home Health Agency Services, 1983."
- "Medicare: Use and Cost of Skilled Nursing Care Facilities, 1983."
- "Medicare: Use of Short-Stay Hospital Services by Aged Inpatients, Annual Summary, 1981."
- "Medicare: Use and Cost of Short-Stay Hospital Services by Beneficiaries with the Principal Diagnosis of Alzheimer's Disease, 1981."
- "Medicare: Liability of Medicare Enrollees Using Physician Services, 1980."
- "Medicare: Use and Cost of Short-Stay Hospital Services by Beneficiaries with the Principal Diagnosis of Diabetes, 1981."
- "Medicare: Use and Cost of Long-Stay Hospital Services, 1982."
- "Medicare: Use and Cost of Short-Stay Hospital Services, 1982."
- "Medicare: Use of Skilled Nursing Facilities, 1980."
- "Medicare: Use of Home Health Services, 1980."

Program Evaluation

Medicaid Program Evaluation

Period: September 1983 - September 1986
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: The Office of Research is conducting a 3-year project to assess the changes made in the Medicaid program as a result of recent legislation. The Medicaid Program Evaluation focuses principally on program changes since the Omnibus Budget Reconciliation Act of 1981, an Act which considerably increased State flexibility in determining eligibility, reimbursement, and coverage under the program. The evaluation addresses the implementation and impact of selected changes in the program to provide knowledge for policy assessment and future legislative change. It is focused on a select list of issues and policy questions.

Status: Three contracts were awarded on September 30, 1983, to conduct the evaluation studies:

- La Jolla Management Corporation, with subcontractor SysteMetrics, is studying home- and community-based care and incentives for family care.
- Abt Associates, with subcontractors Health Economics Research and Compass Consulting, is studying hospital reimbursement changes.
- James Bell Associates, with subcontractors Syracuse University, Urban Institute, SysteMetrics, and National Governors' Association, is studying freedom of choice, eligibility, cost sharing, Federal financial participation, and subsequent legislation, and preparing the annual synthesis.

Interim reports on each task and an interim synthesis report will be available early in 1986.

Medicaid Program Evaluation: Cluster I

Project No.: 500-83-0056
Funding: $ 953,595
Award: Contract
Contractor: La Jolla Management Corporation
11426 Rockville Pike
Rockville, Md. 20852

Description: This project addresses two tasks as part of the Medicaid Program Evaluation. The first deals with the home- and community-based waiver program. Under Section 2176 of the Omnibus Budget Reconciliation Act of 1981, States under a waiver may institute a variety of home- and community-based services to individuals who "but for" the waiver would be in long-term care institutions. The following questions will be addressed: Has the program reduced institutionalization? Has the program reduced costs? Has cost shifting occurred from other programs, specifically Titles XX of the Social Security Act and III of the Older Americans Act? Can we identify the elements of a successful program? The second task deals with financial incentives for family care. Several States provide financial support through direct payments or tax incentives to family members to encourage their assistance to their elderly relatives. The major questions are: What programs are in operation? What have been their costs and savings? Who are the beneficiaries of such programs and what are their characteristics? What are the characteristics of functionally limited persons living in the community that permit them to avoid institutionalization? What are the characteristics of successful programs?

Status: The contract was awarded September 30, 1983. A Report to Congress on Home- and Community-Based Care was submitted to Congress in September 1985. A subsequent interim report will be ready in early 1986.

Medicaid Program Evaluation: Cluster II

Project No.: 500-83-0057
Funding: $ 763,629
Award: Contract
Contractor: Abt Associates
55 Wheeler Street
Cambridge, Mass. 02138

Description: This project addresses inpatient hospital reimbursement as part of the Medicaid Program Evaluation. To help bring hospital costs under control, the Omnibus Budget Reconciliation Act of 1981 granted the States new flexibility in the establishment of inpatient hospital reimbursement methodologies. Major questions are: What responses have States made to the options permitted by Federal law? Have reductions in expenditures resulted? Specifically, what has been the impact of the California program? Two other State programs will be studied for comparison. What have been the effects on recipients and providers of care? Have costs been shifted to private payers? To what degree and in what ways has the implementation of Medicare prospective reimbursement had an impact on State Medicaid programs?

Status: The contract was awarded September 30, 1983. Interim reports will be available in early 1986.

Medicaid Program Evaluation: Cluster III

Project No.: 500-83-0058
Funding: $ 1,449,479
Award: Contract
Contractor: James Bell and Associates, Inc.
1700 North Moore Street, Suite 1622
Arlington, Va. 22209

Description: This project addresses several issues as part of the Medicaid Program Evaluation. The first is freedom-of-choice waivers. Under Section 2175 of the Omnibus Budget Reconciliation Act (OBRA) 1981, States may institute a variety of programs to reduce costs by limiting the provision under Medicaid which guarantees freedom of choice of provider. Major questions are: How have the States responded to this provision? Have there been program savings? How have access to and quality of health care been affected? The second is eligibility. OBRA 1981 contained several changes which directly and indirectly reduced the number of persons eligible for Medicaid. Major questions are: How have the States responded to these provisions? How have eligibility changes in related programs (Aid to Families with Dependent Children and Supplemental Security Income) affected Medicaid enrollment? How have entitlement and expenditures been affected? How has the reduction in Medicaid coverage affected other assistance programs, out-of-pocket expenditures, and costs to hospitals and other payers? The third is cost sharing. Under the Tax Equity and Fiscal Responsibility Act of 1982, States are permitted to impose nominal copayments, with certain limitations, to reduce program outlays, and to instill cost consciousness on the part of the recipients. Major questions are: How have the States responded? What has been the effect of copayments on utilization and costs? The fourth is Federal financial participation. OBRA 1981 provides for the reduction of Federal matching funding for 3 years, beginning October 1, 1982, subject to certain exemptions. Major questions are: Which States were exempted from the reductions and for what reasons? How much did the Federal Government save? How did the States adjust to reduced funding? Fifth, as legislation in 1983, 1984, and 1985 adds further changes to Medicaid, the evaluation will attempt to address the implications of these new provisions. The final task of the project will be to provide for the preparation of an annual interpretation, summary, and synthesis of evaluation results.

Status: The contract was awarded September 30, 1983. Interim reports will be available in early 1986.

Medicare Automated Data Retrieval System

Project No.: HCFA-85-1375
Period: October 1985 - March 1986
Funding: $ 20,800
Award: Contract
Contractor: Howard Marantz
1140 Pleasant Hill Road
Sabastepol, Calif. 72304
Project Officer: Paul Lichtenstein
Division of Health Systems and Special Studies

Description: The Medicare Automated Data Retrieval System (MADRS) will reorganize the Medicare bill and payment records to improve the accessibility of the data. The Office of Research and Demonstrations has a continual need for 100-percent data by geographic region or on individual Medicare beneficiaries or providers for carrying out research studies and for evaluating demonstrations. The current 100-percent bill or payment record files are organized in weekly batches in health insurance claim (HIC) number sequence. To find records for any individual beneficiary, provider, or geographic region, it is necessary to search through all the tapes. MADRS proposes to sort the 100-percent bill payment record file into yearly files and then by geographic region (county) and HIC number. The MADRS system will be indexed by county, provider, and HIC number. Using MADRS, it would be possible to quickly locate the portion of the files where the required data is located and retrieve it for research and demonstration studies.

Status: The programs to create MADRS have been completed. Under the current contract, programs will be tested by producing 1982 MADRS files.

Studies Evaluating Medicaid Home- and Community-Based Services: A Report to Congress

Funding: Intramural
Project Director: Gerald S. Adler
Division of Beneficiary Studies

Description: The Orphan Drug Act of 1982, Public Law 97-414, Section 6(b), directs the Secretary to "report the results of studies currently evaluating home- and community-based health services, and any recommendations for legislative action which might improve the provision of such services, to the Congress." This intramural project produced that report, based on the studies of the waiver program conducted as part of the Medicaid Program Evaluation.

Status: The Medicaid Program Evaluation studies were begun in October 1983. The Congressional Report was submitted to Congress in September 1985.

QUALITY AND COVERAGE

Quality

Development, Pilot Testing, and Refinement of Valid Outcome Measures for the Home Care Setting

Project No.:	18-C-98868/0-01
Period:	September 1985 - August 1986
Funding:	$ 188,766
Award:	Cooperative Agreement
Awardee:	Home Care Association of Washington 12721 30th NE., Suite 201 Seattle, Wash. 98125
Project Officer:	Pete Rhodes Division of Long-Term Care Experimentation

Description: Most efforts to evaluate home health care quality have focused on the structure or the process of care, but have neglected another important perspective: patient outcomes. This project, sponsored by the Home Care Association of Washington (HCAW), is designed to develop, pilot-test, and refine seven patient outcome measures for the quality of care by home health agencies. The project will conduct pilot tests in HCAW member agencies with 40-50 patients participating per agency.

Status: The Health Care Financing Administration approved the proposal effective September 1, 1985. The project is in its early developmental stage.

Geriatric Continence Research Project

Project No.:	**1AA-85-0383**
Period:	**November 1985 - October 1988**
Funding:	**$ 562,653**
Award:	**Interagency Agreement**
Agency:	**Gerontology Research Center** **Francis Scott Key Medical Center** **4940 Eastern Avenue** **Baltimore, Md. 21224**
Project Officer:	**William D. Clark** **Division of Long-Term Care Experimentation**

Description: The Gerontological Research Center at the Francis Scott Key Medical Center, the intramural clinical research center of the National Institute on Aging (NIA), has been selected to conduct a jointly funded research project on geriatric continence of institutionalized patients in a 12-bed unit of the Mason Lord building. The NIA will sponsor this research effort with partial funding from the Health Care Financing Administration (HCFA). The 3-year project will test treatment courses involving behavioral modification techniques with 150 patients who are incontinent of urine, feces, or both. The major objectives of this research project are to:

- Test the medical effectiveness of treatment methodologies across 15 strata for 150 institutionalized patients.
- Determine the cost effectiveness of successful treatment methods being tested.
- Determine the potential value of successful treatments for general use with incontinent patients and publish project results.

Status: The special unit has been prepared for patient care and appropriate staff has been hired and trained. The first group of 12 patients are expected to be admitted to the unit in December 1985.

Nonintrusive Outcome Measures: Identification and Validation

Project No.:	**15-C-98684/9-01**
Period:	**September 1984 - September 1987**
Funding:	**$ 860,679**
Award:	**Cooperative Agreement**
Awardee:	**The Rand Corporation** **1700 Main Street** **Santa Monica, Calif. 90406**
Project Officer	**Lawrence E. Kucken** **Division of Beneficiary Studies**

Description: **The main objective of this project is to develop nonintrusive measures (administrative data) to determine the impact of selected changes in the health care sector, particularly prospective payment and diagnosis-related group (DRG) methodology, on the quality of medical care. A specific goal is to identify short-stay hospital care that may be less than adequate. In addition, medical conditions that appear to be associated with lower levels of care will be identified. A set of nonintrusive outcome indicators for quality care review is proposed.**

Status: **The first stage of the study design has been implemented. Specification of data from the Medicare statistical system has been completed, and analysis has begun. An expert consensus panel has been convened to review the analysis, and to recommend potential medical conditions for further study. In addition, development has begun on chart review protocols for validation of the secondary data that is in the administrative record data.**

Develop Indexes of Hospital Efficiency and Quality

Project No.:	**18-C-98841/5-01**
Period:	**September 1985 - August 1987**
Funding:	**$ 325,220**
Award:	**Cooperative Agreement**
Awardee:	**Commission on Professional and Hospital Activities** **1968 Green Road** **Ann Arbor, Mich. 48106**
Project Officer:	**Lawrence E. Kucken** **Division of Beneficiary Studies**

Description: **This study is designed to produce quality and efficiency indexes by using existing data bases from the Commission on Professional and Hospital Activities and the American Hospital Association. These indexes will provide the basis for monitoring simultaneous changes in efficiency and quality and for measuring efficiency/quality tradeoffs within hospitals.**

Status: **The project is in the early developmental stage.**

Impact of the Prospective Payment System on the Quality of Inpatient Care

Project No.: 15-C-98663/5-01
Period: September 1984 - September 1988
Funding: $ 145,261
Award: Cooperative Agreement
Awardee: Commission of Professional and Hospital Activities
1968 Green Road
P. O. Box 1809
Ann Arbor, Mich. 48106
Project Officer: Lawrence E. Kucken
Division of Beneficiary Studies

Description: This project is congressionally mandated by Public Law 98-21. It will evaluate the effect of the Medicare hospital prospective payment system on the quality of inpatient care received by Medicare patients, by examining several indicators of hospital performance. This examination is to be based primarily on data from the Professional Activity Study maintained by the Commission on Professional and Hospital Activity (CPHA), supplemented by data from several other sources maintained by CPHA.

Status: A detailed research plan is being prepared, and work is beginning on the compilation of the research file that will provide the basis for the empirical study. A preliminary analysis of the data has been performed and is under review. Results of this study will be included in the Annual Report to Congress on the prospective payment system.

Impact of the DRG-Based Prospective Payment System on Quality of Care for Hospitalized Medicare Patients

Project No.:	**18-C-98853/9-01**
Period:	**September 1985 - September 1988**
Funding:	**$ 2,048,798**
Award:	**Cooperative Agreement**
Awardee:	**The Rand Corporation** **1700 Main Street** **Santa Monica, Calif. 90406**
Project Officer:	**Lawrence E. Kucken** **Division of Beneficiary Studies**

Description: **This study will evaluate the impact of the prospective payment system on quality of care. It will assess potential effects of changes in inpatient hospital treatment patterns by examination of the medical record and resultant health status outcomes. Quality measurement scores will be constructed for six medical conditions, before and after the introduction of prospective payment, taking into account:**

- **The nature, timing, and effects of medical procedures rendered.**
- **Disease severity.**
- **Comorbid conditions.**

The effectiveness of medical care treatment will be evaluated by relating quality scores to mortality, readmission rates, and other outcome variables.

Status: **The project is in the early developmental stage.**

Health Status at Discharge Research Project

Project No.: 18-C-98862/01-1
Period: September 1985 - May 1986
Funding: $ 36,892
Award: Cooperative Agreement
Awardee: Northwest Oregon Health Systems
Park Plaza West, Building III, Suite 655,
10700 S.W. Beaverton-Hillsdale Highway
Beaverton, Oreg. 97005
Project Officer: Lawrence E. Kucken
Division of Beneficiary Studies

Description: The purpose of this study is:

- To evaluate a summary instrument for measuring discharge status in the aged population in terms of physical function, mental function, and post-hospital treatment needs.
- To analyze patient status of a random sample of Medicare patients (based on medical record data) to compare functional status before and after the implementation of the prospective payment system. Functional status measurement will utilize a combination of three established measurement scales.

Status: This project is in the early developmental stage.

Prospective Payment Beneficiary Impact Study

Funding: Intramural
Project Directors: Paul W. Eggers and James Lubitz
Division of Beneficiary Studies

Description: The analyses in this study area are designed to measure changes in hospitalization as a result of prospective payment that may impact on Medicare beneficiaries. There are three study areas:

- Analyses of discharge rates and average length of stay.
- Changes in discharge status and post discharge mortality and rehospitalizations.
- Changes in the concentration of selected diagnosis-related groups, diagnoses, and procedures among hospitals.

Status: Baseline data analyses have been performed and are included in the 1984 Annual Report to Congress on prospective payment mandated by Public Law 98-21. First year implementation data (fiscal year 1984) have been analyzed and will be included in the 1985 Annual Report to Congress.

End-Stage Renal Disease

National Kidney Dialysis and Kidney Transplantation Study

Project No.: 95-P-97887/0-03
Period: January 1981 - September 1984
Funding: $ 776,750
Award: Grant
Grantee: Battelle Memorial Institute
4000 N.E. 41st Street
Seattle, Wash. 98105
Project Officer: Carl Josephson
Division of Program Studies

Description: The purpose of this study is to analyze the impact of alternative types of therapy on end-stage renal disease (ESRD) patients. Patient outcomes are measured in terms of the patient's quality of life, quality of care, cost of care, and rehabilitation status. Data collection instruments included direct patient interviews, facility-based medical records abstracts, completion of patient medical-expense diaries, and the Health Care Financing Administration program data records from entitlement forms, provider certification records, facility survey files, facility cost reports, facility and provider reimbursement records, and other medical information files.

Status: The study has been completed. In general, the study found that patients are not randomly assigned to different treatment modalities and that case-mix differences do affect patient outcomes. There were significant differences in the measures of quality of care and quality of life by type of therapy, and these differences persisted after adjusting for differences in patient case mix. Also, significant declines in labor-force participation were associated with onset of the renal disease. In the study, only about one-half of the patients used rehabilitation services, and their use of services varied significantly across types of treatment modalities. Among the patients in the study for whom peritoneal dialysis was most appropriate, the choice of continuous cycling peritoneal dialysis (CCPD) represented an increasingly attractive alternative to continuous ambulatory peritoneal dialysis (CAPD) or intermittent peritoneal dialysis, since the patients were found to have a lower incidence of peritonitis, fewer hospital admissions, and fewer days of hospitalization. Both short- and long-term complications were associated with organ transplantation. Serious complications were more likely to be present among ESRD patients who had experienced a failed transplant than among patients who had successfully functioning allografts. These differences, however, were not attributable to patient case-mix differences because the two patient transplant groups did not differ with regard to age, sex, race, education, and primary disease diagnosis.

The major papers were:

- "Case Mix, Treatment Modalities, and Patient Outcomes: Results of the National Kidney Dialysis and Kidney Transplantation Study."
- "A Comparative Assessment of the Quality of Life of Patients on Four Treatment Modalities."
- "Functional Impairment, Work Disability, and the Availability and Use of Rehabilitation Services by Patients with Chronic Renal Failure."
- "Labor Force Participation Among ESRD Patients."
- "Health Services Utilization and Disability Days: Indicators of the Quality of Patient Care Among ESRD Patients."
- "Premorbid and Post-Treatment Functional Limitations Among Patients with Chronic Renal Failure."
- "Complexities in the Treatment of ESRD: Economic Efficiency and Treatment Modality Prescription."
- "The Demographic Characteristics of the National Kidney Dialysis and Kidney Transplantation Study: A Comparison With the ESRD Population."
- "The Use of Rehabilitation Services by Patients With Chronic Renal Failure."
- "Peritonitis, Hospital Admissions, and Days Hospitalized Among Patients on CAPD and CCPD: A Comparative Assessment."
- "Extrarenal Complications Among Kidney Transplantation Recipients."
- "Travel Costs Incurred by ESRD Patients."
- "National Policies for Treatment of End-Stage Renal Disease."
- "A Comparative Assessment of the Quality of Life of Successful Kidney Transplant Patients According to Source of Graft."
- "ESRD Patient Preferences for Dialysis and Transplantation."
- "A Comparison of the Utilization of Hospital Services Among ESRD Patients on Four Treatment Modalities."
- "The Financial Status of ESRD Patients."
- "National Kidney Dialysis and Kidney Transplantation Study: A Summary of Results."

The final project report is being published under the Health Care Financing Special Report Series. It is expected to be available Spring 1986.

Design of a Demonstration and Assessment of Competitive Health Insurance Proposals in the End-Stage Renal Disease Program

Project No.: 14-P-98275/3-01
Period: April 1983 - April 1987
Funding: $ 879,694
Award: Grant
Grantee: The Urban Institute
2100 M Street, NW.
Washington, D.C. 20037
Project Officer: Marla Aron
Division of Health Systems and Special Studies

Description: This project will determine the feasibility of demonstrations to test competitive financing approaches in the end-stage renal disease (ESRD) program, with possibilities including:

- Competitive bidding.
- Global capitation covering all medical care costs.
- Partial capitation covering only outpatient ESRD services.
- Voucher payment allowing patients to share in the financial savings of cost-reducing shifts.

If competitive approaches are feasible, the Urban Institute will develop the demonstration model and an evaluation design. The evaluation will consider:

- Structure of the experimental treatments.
- Methods to ensure randomization.
- Determination of appropriate capitation amounts.
- Design of a reinsurance system.
- Estimate of sample sizes.

Status: The grantee assisted the Health Care Financing Administration in the development of its intramural end-stage renal disease competitive bidding demonstration. It has submitted a detailed plan for the evaluation of that demonstration. Urban Institute is collecting baseline data and will analyze the data relating to case-mix, quality, and patient-choice factors. Reports have been submitted on the competitive bidding models. These reports provide the conceptual background and consider practical implementation issues of the various bidding models.

Developing Incentive Systems to Increase the Supply of Cadaveric Kidneys for Transplants

Project No.:	**14-C-98333/1-02S2**
Period:	**June 1983 - March 1986**
Funding:	**$ 369,311**
Award:	**Cooperative Agreement**
Awardee:	**Brandeis University** **415 South Street** **Waltham, Mass. 02254**
Project Officer:	**Paul W. Eggers** **Division of Beneficiary Studies**

Description: Using survey methodologies, this project will evaluate alternative approaches to increasing the participation of nongovernmental actors in organ procurement programs. The end result of the research will be a set of Health Care Financing Administration policy recommendations designed to improve the effectiveness of organ procurement networks and so increase the number of kidneys available for transplantation.

Status: The cooperative agreement was initiated June 1983. The methodology entails surveys of major participants in the organ procurement process. These include hospital administrators, directors of nursing, intensive care unit nurses, and neurosurgeons. Each group of these professionals was administered a questionnaire designed to elicit information concerning their knowledge and personal opinions about organ procurement, perceived barriers to organ procurement, and potential recommendations for improving the organ procurement process. In addition, donor families and the general public were interviewed to collect information on public attitudes toward organ procurement. Data collection has been completed and the project is in the analysis phase. Much of the effort in 1985 in this cooperative agreement has been in support of the National Task Force on Organ Transplantation and the Federal Office of Organ Transplantation. The results of this work will be incorporated into the Task Forces' Report to Congress on Organ Transplantation.

Relative Effectiveness and Cost of Transplantation and Dialysis in End-Stage Renal Disease

Project No.: 14-C-98372/5-01
Period: September 1983 - September 1988
Funding: $ 1,110,383
Award: Cooperative Agreement
Awardee: University of Michigan
Department of Epidemiology
109 Observatory Street
Ann Arbor, Mich. 48109
Project Officer: Carl Josephson
Division of Program Studies

Description: This study will perform a comprehensive assessment of the cost effectiveness of end-stage renal disease treatment under different treatment modalities, an assessment of the impact of cyclosporine on transplant success, and a life-table analysis of risk factors for patient and graft survival. The study will use data from the Michigan Kidney Registry, supplemented by survey information and medical record abstractions. Because of the design of the study, it is anticipated that the project will demonstrate the utility of a longitudinal, patient-specific data system for policy decisionmaking at the Federal level.

Status: Activities in the three main research areas—quality of life, survival, and costs—have generally proceeded as planned in the second year. Most of the 500 patient interviews for the quality of life component have been completed for the first cohort of patients (November 1, 1981 - October 31, 1983). Univariate and multivariate survival analyses have been performed on the full universe of 1,842 patients which are included in the first cohort. Development of the cost analysis component has lagged somewhat because of problems in obtaining the historical reimbursement files. Additionally, progress continues in secondary goals of the research project, such as identification of diabetic etiological factors in end-stage renal disease, use of the Michigan Kidney Registry data for a variety of research purposes (for example, studies in geriatric nephrology), and studying the relationship between immunosuppressive agents and malignant tumors.

Organ Donor Education Project

Project No.:	**14-P-98437/0-01**
Period:	**September 1983 - March 1985**
Funding:	**$ 41,410**
Award:	**Grant**
Grantee:	**Oregon Donor Program P.O. Box 532 Portland, Oreg. 97207**
Project Officer:	**Arne Anderson Division of Health Systems and Special Studies**

Description: The purpose of the demonstration is to test whether the number of organ donors would be increased by the use of videotapes aimed at increasing public awareness of the need for organs. Two tapes were produced--a public education tape shown to applicants for drivers' licenses in 60 Oregon Department of Motor Vehicle (DMV) Offices, and an informational tape to train DMV personnel to promote organ donation.

Status: Scripts for the two audiovisual tapes and filming have been completed. The tapes were exhibited in DMV offices from July through September 1984. An evaluation design was developed with assistance from the Health Care Financing Administration and is being implemented by the grantee. The final evaluation report from the grantee is expected in early 1986.

Costs, Outcomes, and Competiton in the End-Stage Renal Disease Program

Project No.: 18-P-98056/3
Period: August 1981 - September 1984
Funding: $ 407,096
Award: Grant
Grantee: The Urban Institute
2100 M Street, NW.
Washington, D.C. 20037
Project Officer: William J. Sobaski
Division of Reimbursement and Economic Studies

Description: This project will aid in the overall assessment of the End-Stage Renal Disease (ESRD) program by studying three aspects:

- The determinants of the total cost of the program.
- Some measures of the health outcomes produced by the program.
- Alternative ways of organizing and improving the services.

Particular attention will be given to the effects of competition on the cost and quality of care among facilities in an area.

Status: Three major papers have been produced thus far under this grant:

- "Pro Competitive Health Insurance Proposals and their Implications for the ESRD Program."
- "Competition and Efficiency in the ESRD Program."
- "Financial Incentives and Policy Goals of the End-Stage Renal Disease Program."

The first paper concludes that there are numerous ways to induce more competitive behavior in the delivery of ESRD service, especially maintenance dialysis, although there are significant implementation problems with some strategies. The second paper concludes that analysis of cost alone cannot determine appropriate reimbursement levels, because that determination requires a prior political decision of the appropriate level of amenities. The third paper concludes that the precise legislative intent regarding the goals of the ESRD program is ambiguous, particularly to treatment objectives. In December 1984, a report of recommendations for revising ESRD system central files was received. The final report is expected by late 1986.

End-Stage Renal Disease Nutritional Therapy Study

Period: September 1984 - August 1993
Project Officer: Bonnie Edington
Division of Health Systems and Special Studies

Description: In accordance with the Congressional mandate (Public Law 96-499), this study will seek to determine (1) the extent to which the commencement of nutritional therapy in early renal failure (utilizing controlled protein substances) can retard or arrest the progression of the disease, resulting in substantive deferment of dialysis, and (2) the administrative, financial, and other aspects of making nutritional therapy generally available under Medicare. The study will be conducted jointly by The National Institute of Health (NIH) and the Health Care Financing Administration. Initiation of full-scale clinical trials will be preceded by a developmental phase and a pilot test.

Status: The developmental phase began in September 1984. NIH awarded six clinical centers to conduct the clinical trials and the preliminary phases. The clinical centers are:

Division of Nephrology and Hypertension
Harbor-University of California at Los Angeles
Medical Center
1000 West Carson Street
Torrance, Calif. 90509

Veterans Administration Medical Center
Building 3
Iowa City, Iowa 52240

Department of Pharmacology and Experimental Therapeutics
Johns Hopkins University
725 North Wolfe Street
Baltimore, Md. 21205

New England Medical Center
Box 784
171 Harrison Avenue
Boston, Mass. 02111

Renal Division
Brigham and Women's Hospital
75 Francis Street
Boston, Mass. 02115

Vanderbilt University Medical Center
Division of Nephrology
Room B-2214 MCN
Nashville, Tenn. 37232

A data coordinating center has also been awarded:

Department of Biostatistics
The Cleveland Clinic Foundation
9500 Euclid Avenue
Cleveland, Ohio 44106

The developmental phase concluded October 1985. A clinical protocol, forms manual, and operations manual have been produced. Beginning in early 1986, 108 patients are expected to enter the 2-year pilot study at six clinical centers throughout the United States. Patients within a specific range in level of kidney function will be entered into the screening period, and only those manifesting a specific minimum in the rate of disease progression (decline in kidney function) during the 3-month screening phase will enter the 3-month baseline period. Following baseline, patients will be divided into two groups, based on their level of kidney function, and, within each group, randomly assigned to one of three nutritional therapy regimens for a period of 18 months. The results will be analyzed before the third phase of the project begins.

Severity of Illness in End-Stage Renal Disease Population in Northern Florida

Project No.:	14-C-98696/4-01
Period:	September 1984 - September 1986
Funding:	$ 509,356
Award:	Cooperative Agreement
Awardee:	University of Florida Grinter Hall Gainesville, Fla. 32610
Project Officer:	Paul W. Eggers Division of Beneficiary Studies

Description: The purpose of this study is to develop and test measures of severity of illness that predict resource consumption levels in the end-stage renal disease (ESRD) program. These measures will be based on the acute physiology and chronic health evaluation (APACHE) system, which was developed to measure therapeutic effort and resource costs in intensive care units. Two components of APACHE, the therapeutic intervention scoring system (TISS) and the acute physiology score (APS) will be adapted to the special characteristics of the ESRD patient receiving dialysis. The TISS and APS will then be used to measure ESRD case mix and resource consumption.

Status: The major activity of the first year of this study involved the development of an instrument to measure severity of illness variations in the chronic hemodialysis population. The instrument includes physiologic measures, dialysis treatment variations, measures of comorbidities, as well as socioeconomic and behavioral factors. Final revisions to the instrument were made in June 1985, based on comments from a technical advisory panel and reviews of patients charts in ESRD facilities to determine data availability. Seven hemodialysis units have agreed to participate in the study. The number of patients to be included will be approximately 560. Data collection began in Fall 1985. A final report is scheduled for Spring 1987.

Comparison of Quality of Life of End-Stage Renal Disease Patients

Project No.: 14-C-98642/5-02
Period: September 1984 - September 1986
Funding: $ 102,976
Award: Cooperative Agreement
Awardee: University of Minnesota Family Study Center
1114 Social Sciences
Minneapolis, Minn. 55455
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: The objective of this study is to evaluate the quality of life of patients on different therapeutic regimens for end-stage renal disease. The following groups will be compared:

- Transplant recipients randomly allocated to conventional immunosuppression.
- Transplant recipients randomly allocated to immunosuppression with cyclosporine.
- Patients on center hemodialysis.
- Patients on continuous ambulatory peritoneal dialysis.
- A historical control of patients who received transplants in 1970-73.

Clear-cut differences in survival do not necessarily distinguish among the above treatment modalities. Comparative quality of life is, therefore, an important criterion.

Status: This study is entering its second and final year. Information is available on 83 center hemodialysis patients, 510 continuous ambulatory peritonical dialysis (CAPD) patients, and 91 transplant recipients (40 receiving conventional immunosuppressive therapy and 51 cyclosporine). There are pronounced differences in objective measures of rehabilitation. More than 80 percent of male transplant recipients with functioning grafts work or are in school at least part-time (a proportion that is consistent with that seen nationally), but only 30 percent of male center hemodialysis patients have achieved an equal level of rehabilitation. Of the male CAPD patients, 46 percent work or attend school at least part-time. Patterns among female patients are similar but less pronounced. Transplant patients also have the best subjective sense of well-being, but the differences are smaller in magnitude. Transplant patients who received cyclosporine score consistently higher on measures of well-being than those on conventional therapies, in part because of the lower incidence of rejection episodes and of complications of steroid therapy.

Waiver for the Northwest Kidney Center, Seattle, to be Reimbursed Directly for Providing Home Dialysis Training Services

Project No.:	**95-C-98485/0-01**
Period:	**November 1984 - October 1987**
Award:	**Cooperative Agreement**
Awardee:	**Northwest Kidney Center 700 Broadway Seattle, Wash. 98118**
Project Officer:	**Marla Aron Division of Health Systems and Special Studies**

Description: The Northwest Kidney Center (NKC) is conducting a pilot test of a home dialysis training program. Under this program, NKC will provide home dialysis training services to 6-10 patients per year at the Central Washington Hospital in Wenatchee and will also provide training in the homes of one to two hepatitis B antigen positive patients per year. The home dialysis training will be provided for 2-3 weeks depending on the individual patient. Training will be on a 5-day-week basis with 3 weekly hemodialyses, or continuously in the case of continuous ambulatory peritoneal dialysis. The goal is to show that a regionalized home dialysis training program will increase the number of patients choosing to dialyze at home.

Status: During the second project year, the demonstration population will include patients who carry the HTLV-III antibody. The Olympic Peninsula Kidney Center in Bremerton has hired a home dialysis training nurse, so it will no longer participate in the demonstration.

Comparative Analysis of the Cost and Outcomes of Kidney Transplants

Project No.: 14-C-98564/0-02
Period: July 1984 - July 1987
Funding: $ 1,072,628
Award: Cooperative Agreement
Awardee: Battelle Human Affairs Research Center
4000 NW. 41st Street
Seattle, Wash. 98105
Project Officer: Paul W. Eggers
Division of Beneficiary Studies

Description: This is a multicenter observational study of the impact of cyclosporine on renal transplantation. A sample of 300 patients contributed by eight major centers experienced in the use of cyclosporine will be studied in depth. Detailed information on outcomes (mortality, complications, disability) and costs will be collected on this sample and analyzed in terms of major prognostic factors. In addition, extensive data of a medical or biologic and of a sociologic nature will be obtained. The representativeness of the sample will be validated by comparison with the universe of patients treated with cyclosporine for whom more limited information is available in the Health Care Financing Administration Medical Information System data base.

Status: A collaboration with the scientific studies committee of the American Society of Transplant Surgeons was formalized and a working group of physicians to advise and guide the biomedical component of the study was empaneled and met twice. The supplementary questionnaires designed to gather medical data were drafted and finalized after review by the medical working group. Patient selection criteria have been finalized. Participating transplant centers have been selected and subcontracts for data acquisition have been negotiated. The second year of the project will be devoted largely to data collection.

Assessment of Emerging Technologies for the Treatment of End-Stage Renal Disease

Funding: Intramural
Project: Henry Krakauer
Director: Division of Beneficiary Studies

Description: The purpose of this project is to evaluate the utility of new treatment methodologies emerging into clinical practice in end-stage renal disease. Data currently available in the Health Care Financing Administration Medical Information System data base and supplementary information collected as needed were used to analyze outcomes (mortality, morbidity, disability, and cost) associated with the use of the new methodologies. Prognostic factors that significantly affect the outcomes were identified and their impact measured. Finally, projections of the consequences of adoption of the methodologies were made to obtain estimates of their medical impacts and of their effects on program expenditures.

Status: The impact of the use of cyclosporine in renal transplants performed in 1982 and 1983 were analyzed in terms of the effects on graft and patient survival and on patient costs. A parallel analysis was performed on the use of donor-specific transfusions administered to recipients of living-donor renal transplants. The results of these studies were forwarded to the Office of Organ Transplantation in the Public Health Service and will be included in a Report to Congress scheduled for release in December 1985. In addition, a conference on the state of the art and gaps in knowledge concerning dialytic therapies was convened. Partially as a result of this conference, the Health Care Financing Administration and the National Institute of Arthritis, Diabetes, Digestive, and Kidney Diseases have agreed to jointly sponsor a national registry on end-stage renal disease. Work on this registry is under way. Finally, a conference on the use of monoclonal antibodies was convened to ascertain the current state of use of these agents. Monoclonal antibodies are used to prevent rejection of kidney transplants. Experimental use of these agents is being conducted in bone marrow transplants and the treatment of solid, as opposed to hematologic, cancers. It was determined that the emergence of the latter two applications as practical technologies is probable in 3 to 5 years.

End-Stage Renal Disease Annual Report to Congress

Funding: Intramural
Project: Paul Eggers
Director: Division of Beneficiary Studies

Description: The Office of Research and Demonstrations (ORD) has the responsibility for producing three sections included in each year's report to Congress (Public Law 95-292). These are: End-stage renal disease (ESRD) patient morbidity, ESRD patient mortality, and ancillary hospital costs.

Status: ORD has produced the three sections above for the following reports:

- 1981 ESRD Annual Report to Congress, HCFA Pub. No. 82-02144.
- 1982 ESRD Annual Report to Congress, Medicare Annual Report, Fiscal Year 1981, HCFA Pub. No. 02156.
- 1983 ESRD Annual Report to Congress, submitted for departmental approval.
- 1984 ESRD Annual Report to Congress, submitted for departmental approval.

Urban Clinics

Urban Health Clinics Demonstration

Project No.: 500-81-0048
Period: September 1981 - December 1985
Funding: $ 891,089
Award: Contract
Contractor: Technassociates, Inc.
1700 Rockville Pike, Suite 200
Rockville, Md. 20852
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: The Rural Health Clinics Act of 1977 (Public Law 95-210) mandated that the Department of Health and Human Services conduct demonstrations in urban medically underserved areas to test the relative advantages and disadvantages of cost-based and fee-for-service reimbursement for physician-directed clinics that employ physician assistants or nurse practitioners. The demonstration involves approximately 36 clinics in California and Tennessee. An appropriate definition of medically underserved areas will also be established by the Public Health Service.

Status: The 2-year operational phase of the demonstration ended on July 31, 1985. The quality of care abstracting process has been completed and the data is currently being analyzed by the physician staff. As of July 31, 1985, claims have been processed for 3,549 beneficiaries that were seen by a physician assistant or nurse practitioner. These claims represent 11,226 clinic visits, and a total of $306,129 has been paid to participating clinics. A draft final report is expected by Spring 1986.

Evaluation of the Urban Health Clinics Demonstration

Project No.: 500-82-0025
Period: September 1982 - August 1986
Funding: $ 806,666
Award: Contract
Contractor: Arthur D. Little, Inc.
Acorn Park
Cambridge, Mass. 02140
Project Officer: Spike Duzor
Division of Health Systems and Special Studies

Description: The purpose of this contract is to evaluate the Urban Health Clinics Demonstration (Project No. 500-81-0048). The evaluation will focus on use, cost, and quality of services.

Status: The data resources report and literature review were completed January 1983. The research design report and final report were delayed because of delays in implementation of the demonstration. The design report was submitted in December 1983, and the final report is expected in August 1986.

Clinical Social Worker

Medicare Clinical Social Worker Demonstration

Project No.: 500-82-0053
Period: September 1982 - December 1986
Funding: $ 541,301
Award: Contract
Contractor: SRI International
333 Ravenswood Avenue
Menlo Park, Calif. 94025
Project Officer: Kathleen Connors
Division of Health Systems and Special Studies

Description: The Omnibus Reconciliation Act of 1980 (Public Law 96-499) mandated that the Department of Health and Human Services conduct a demonstration to determine the effects of making the services of clinical social workers more generally available under Medicare. The demonstration will allow direct reimbursement to clinical social workers for their services rather than through a physician or clinic. This contract is for the design, implementation, and assessment of the direct reimbursement demonstration.

Status: In the initial phase of the project, the contractor identified the demonstration sites and carriers that process claims and collect information. Southern California is the experimental site with Transamerica Occidental as carrier, and Northern California is the control site with Blue Shield of California as carrier. Initiation of services by clinical social workers began January 1984. Major tasks accomplished include establishing administrative claims-processing systems to be implemented by the Medicare carrier in the test site; training, marketing, and registering 1,500 clinical social workers in Southern California; and implementing direct reimbursement in seven Southern California counties where 1.2 million Medicare beneficiaries live. As of December 1984, approximately 400 beneficiaries had seen 150 clinical social workers participating in the demonstration.

Other Coverage

Study of Medicare-Funded Heart Transplants

Project No.:	**500-81-0051**
Period:	**September 1981 - July 1985**
Funding:	**$ 1,626,294**
Award:	**Contract**
Contractor:	**Battelle Human Affairs Research Centers 4000 NE. 41st Street Seattle, Wash. 98105**
Project Officer:	**Joel H. Broida Division of Reimbursement and Economic Studies**

Description: This project was designed to study the scientific, economic, ethical, and social impact of a decision of coverage and reimbursement of heart transplantation for beneficiaries of the Medicare program. The principle components of the study included the collection of information on survival rates of heart transplant patients and the total costs related to this procedure. In addition, analyses of information on organ donation, organ procurement, legal and ethical issues, and quality of life were carried out. The study was completed and a final report was written and submitted to the Health Care Financing Administration in accordance with the provisions of the contract.

Status: The final report, which consists of an Executive Summary and five additional volumes, was released by the Secretary of the Department of Health and Human Services at a press conference on May 2, 1985. Copies of the Executive Summary and Volumes 1-5 are available from the National Technical Information Service, accession numbers PB85-213213/AS and PB85-213205/AS.

Evaluation of the Medicare Mental Health Demonstration

Project No.:	100-80-0148
Period:	September 1980 - June 1985
Award:	Contract
Contractor:	Macro System, Inc. 8630 Fenton Street Silver Spring, Md. 20910
Co-Project Officers:	Sharman Stephens Office of the Assistant Secretary for Planning and Evaluation Tony Hausner Division of Long-Term Care Experimentation

Description: This project evaluates the utilization and cost implications of a demonstration encompassing 40 sites that waived the physician supervision requirements for Medicare reimbursement to mental health centers. Study areas will focus on assessment of impact of this waiver on mental health services, utilization patterns, overall cost to the Medicare program, and administrative and operational capacity of the participating mental health centers. The Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services, is funding this project and administering it jointly with the Health Care Financing Administration.

Status: Marco Systems submitted the final report in September 1985. The project increased the utilization rate by enrollees from .2 percent to .4 percent from the baseline to the demonstration period. It reached a previously unserved population, largely females 65 years of age or over. The charges per encounter increased by 4 percent from the baseline to the demonstration period, whereas charges per hour for partial hospitalization decreased by 25 percent. Some 55 percent of the beneficiaries had charges less than $250. ASPE plans to award a new contract to assess the impact of the demonstration on total health care utilization.

Evaluation of Obstetrical Access Pilot Project

Project No.: 11-P-97578/9-02
Period: March 1980 - August 1984
Funding: $ 203,370
Award: Grant
Grantee: California Department of Health Services
714-744 P Street
Sacramento, Calif. 95814
Project Officer: Tony Hausner
Division of Long-Term Care Experimentation

Description: The purpose of the grant was to conduct an evaluation of the Obstetrical Access Pilot Project (Project No. 11-P-97223/9-03) which was completed in March 1983. The project tested the hypothesis in 10 clinical sites that the provision of early access to obstetrical services for low-income pregnant women would reduce subsequent morbidity of both infants and mothers. Services included health education, nutrition, and psychosocial assessments, in addition to prenatal, delivery, and postpartum services.

Status: The grantee submitted a final report in February 1985. The key findings of the evaluation were: the low birthweight rate was 4.7 percent for the demonstration group compared with 7 percent for a matched control group; and the project estimated that there was a 2-to-1 benefit-cost ratio in the first year resulting from a savings in neonatal intensive care services. The State of California approved legislation in 1984 authorizing the enhancement of prenatal care to MediCal recipients on a statewide basis and is in the process of submitting an amendment to the State plan to cover these services under the regular MediCal program. The final report is available from the National Technical Information Service, accession number PB85-173797/AS.

Impact of Psychological Intervention on Health Care Utilization and Costs: A Prospective Study

Project No.: 11-C-98344/9-02
Period: September 1983 - September 1988
Funding: $ 967,185
Award: Cooperative Agreement
Awardee: Hawaii State Department of Social Services and Housing
P.O. Box 339
Honolulu, Hawaii 96809
Project Officer: Andrew K. Solarz
Division of Health Systems and Special Studies

Description: The Medicaid population of the island of Oahu, Hawaii, is being randomly assigned (two-thirds into the experimental group and one-third into the control group) in this prospective study of the effects of short-term psychological treatment on subsequent Medicaid utilization. The clinical model used is based on the delivery of specific psychological services for specific conditions. The focus of the study is on three groups of Medicaid eligibles: the upper 15 percent of health care utilizers, individuals with specific illnesses that have psychosomatic components, and the group 55 years of age or over. In each case, previous studies have indicated that treatment has the potential to effect reduced utilization of total health care services. This demonstration is unique in that it is being done on a Medicaid population, whereas previous studies have been with health maintenance organization groups, Blue Cross members, and other nonindigent groups. A comparison group of Federal employees, randomized and stratified in the same manner, is also eligible for the same services.

Status: Space has been leased on the island of Oahu for a counseling center, known as the Biodyne Center. Six clinical therapists have joined the staff and have completed special training in the clinic's form of short-term therapy. Training manuals and videotapes have been produced. Client intake began in May 1984, and approximately 1,000 clients participated in treatment through 1985.

New Jersey Mobile Intensive Care System

Project No.:	95-P-98352/2-01
Period:	November 1983 - October 1986
Award:	Grant
Grantee:	New Jersey State Department of Health CN 363 Trenton, N.J. 08625
Project Officer:	Cynthia K. Mason Division of Hospital Experimentation

Description: The purpose of the Mobile Intensive Care Unit (MICU) system is to demonstrate the cost effectiveness of New Jersey's approach to provision of emergency, advanced life-support services. Paramedics and advanced life-support equipment are transported in the MICU vehicle, while emergency patient transportation will continue to be provided by volunteer ambulance squads.

Status: Starting November 1, 1983, Medicare, Medicaid, and other third-party payers began covering MICU charges as an outpatient service. For Medicare, the charge is paid under Part B, unless the patient is admitted to a hospital. Under such circumstances, the MICU charge is included on the inpatient bill. In addition, the Health Care Financing Administration agreed to retroactively reimburse New Jersey hospitals under Part A for MICU services rendered during the period January-October 1983. As of October 1985, there were 54 MICU vehicles operating out of 37 New Jersey hospitals.

Evaluation of the Impact of Second Opinions for Elective Surgery

Project:	500-78-0047
Period:	September 1978 - October 1984
Funding:	$ 2,225,791
Contractor:	Abt Associates, Inc. 55 Wheeler Street Cambridge, Mass. 02138
Project Officer:	Alan S. Friedlob Division of Long-Term Care Experimentation

Description: The objective of this evaluation is to determine the effect of formal second-opinion programs on surgery rates, surgical costs, and the health of patients who forego surgery as a result of obtaining a second opinion. The basis of the evaluation is two voluntary Medicare Second Surgical Opinion Programs (SSOP) in New York City and Detroit, the State of Massachusetts' mandatory Medicaid SSOP, and the Health Care Financing Administration's (HCFA) public information, second surgical opinion program.

Status: The final report was completed Spring 1985. Principal findings from this evaluation were:

- The Massachusetts Medicaid mandatory SSOP was estimated to result in a total reduction of 18 percent in the surgery rate for the eight procedures included in the program. Approximately 90 percent of this reduction was attributed to the indirect effects of the program (for example, sentinel effects).

- Net savings in the Massachusetts Medicaid mandatory SSOP were estimated at $1 million annually, with about $4 saved for every $1 spent on the program.

- Both the Massachusetts mandatory SSOP and the New York voluntary Medicare SSOP were found to have virtually no effect on the health outcomes of participants. These programs caused relatively few persons to change treatment mode and those who did experienced little, if any, effects on health.

- In the voluntary Medicare SSOP demonstrations, program use was quite low (for example, about 2 percent of beneficiaries in New York). Study findings corroborate an earlier Report to Congress that did not support the desirability of waiving Medicare cost sharing for voluntarily sought second opinions.

An executive summary of the final report has been prepared as a working paper entitled, "Second Surgical Opinion Programs: An Analysis of Public Policy Options," and is available from the Office of Research and Demonstrations. The final report may be obtained from the National Technical Information Service.

Medigap Study of Comparative Effectiveness of State Regulations

Funding: Intramural
Project Director: Judith Sangl
Division of Reimbursement and Economic Studies

Description: Section 507 of Public Law 96-265, the Social Security Disability Amendments of 1980, requires a comprehensive study and evaluation of the comparative effectiveness of various State approaches to the regulation of Medicare supplemental policies in:

- Limiting marketing and agent abuse.
- Assuring informed consumer choice.
- Promoting policies with reasonable economic benefits.
- Reducing the purchase of unnecessary duplicative coverage.
- Improving price competition.

Section 507 also states that the study shall address the need for standards or certification of health insurance policies, other than Medicare supplemental policies, sold to Medicare beneficiaries.

Status: A consumer survey of Medicare beneficiaries in six States and an industry survey of the companies that sell insurance to them were conducted by SRI International under Health Care Financing Administration contract 500-81-0050. The final report of the consumer survey was completed in Fall 1983 and that of the industry survey was completed in May 1984. The consumer report found that three State actions affected the purchase of higher quality policies. They were:

- Establishing minimum benefit requirements.
- Setting minimum loss ratios.
- Distributing consumer guides.

Although State regulations seemed to have less impact on sales abuse, two strategies—distributing consumer guides and issuing press releases—appeared to have some beneficial effect. Finally, the distribution of consumer guides was associated with greater consumer knowledge of Medicare or of the policies purchased. The Report to Congress will be based largely on the consumer survey results. The report is forthcoming.

Foot Care Coverage Study

Funding: Intramural
Project Alvin Freedman
Directors: Division of Reimbursement and Economic Studies

Description: Public Law 96-499, Section 958(g), directs the Secretary of Health and Human Services to conduct a study involving a comprehensive analysis of the cost effects of alternative approaches to improving coverage under Title XVIII of the Social Security Act for the treatment of various types of foot conditions. The study has involved: meetings and discussions with professional and Federal experts; staff reviews of literature and relevant statistical information; a Federal Register notice soliciting information and comments from the public; a survey of State Plans for Medical Assistance; an independent study by the Center for Health Services and Policy Research at Northwestern University; and actuarial estimates of the costs of eliminating certain presently excluded or specifically restricted types of expenses for treatment of foot conditions. The study examined present Medicare benefits for the treatment of foot conditions as specified in the law and its implementing regulations and manuals. Possible ways for improving coverage were identified, and the effects these changes could have on beneficiary health status and on the pattern of sources now used for financing foot care treatment were considered. The report concluded that the coverage provisions of present law as they apply to foot care are adequate, and that the present coverage provisions should not be changed.

Status: The report was submitted to the Congress on August 16, 1985.

Registered Dietitians in Home Care

Funding: Intramural
Project Marni Hall
Director: Division of Reimbursement and Economic Studies

Description: Section 958 of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980, directs the Department of Health and Human Services to conduct a study of "the circumstances and conditions under which services furnished by registered dietitians should be covered as a home health benefit under Title XVIII of the Social Security Act." The study has three objectives:

- To assess Medicare beneficiaries' needs for direct clinical counseling by registered dietitians in the home.
- To explore alternative methods for coverage and reimbursement.
- To estimate utilization rates and costs for the alternative methods of coverage and reimbursement.

Status: The draft report is currently under review within the Department of Health and Human Services and is expected to be submitted to Congress in 1986.

Home Respiratory Therapy Services

Funding: Intramural
Project Director: Marni Hall, Division of Reimbursement and Economic Studies

Description: Section 958 of Public Law 96-499, the Omnibus Budget Reconciliation Act of 1980, requires that the Department of Health and Human Services conduct "a study of the circumstances and conditions under which services furnished with respect to respiratory therapy should be covered as a home health benefit under Title XVIII of the Social Security Act." This study evaluates these issues and examines the present "state of the art" in respiratory therapy and the current availability of respiratory therapy services. It also examines the medical and economic ramifications of expanding Medicare benefits to include those home services provided by respiratory therapists.

Status: The draft report is currently under review within the Department of Health and Human Services and is expected to be submitted to Congress in 1986.

Alcoholism Services Demonstration Projects

Period: September 1981 - January 1986
Project Officer: Andrew K. Solarz
Division of Health Systems and Special Studies

Description: The following six projects are a collaborative demonstration between the Office of Research and Demonstrations, Health Care Financing Administration, and the National Institute on Alcohol Abuse and Alcoholism, Public Health Service. These demonstration projects are designed to test the feasibility and cost effectiveness of providing limited coverage for alcoholism treatment services given in freestanding (nonhospital) treatment centers. Each project is uniformly using the following service limits for Medicare and/or Medicaid services:

- Alcohol detoxification--No limit on episodes.
- Inpatient treatment--Up to 30 days per year.
- Outpatient treatment--Up to 45 visits per year.

Alcoholism Services under Medicare: Connecticut Demonstration

Project No.: 95-P-97968/1-04
Funding: $ 324,046
Grantee: Connecticut Alcohol and Drug Abuse Commission
999 Asylum Avenue
Hartford, Conn. 06105

Status: Coverage of services in Connecticut was initiated July 1, 1982. The State has 12 providers participating in the demonstration in Medicare only. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration-awareness program has been developed within the target area. The project is in its fourth year of funding. Through July 1985, approximately 1,050 Medicare beneficiaries entered treatment at the 12 provider sites. The project is scheduled to end on December 29, 1985.

Alcoholism Services under Medicare and Medicaid: Illinois Demonstration

Project No.: 95-P-97971/5-04 (Medicare)
Funding: $ 148,018
Award: Grant
Grantee: Department of Alcoholism and Substance Abuse
901 Southwind Road
Springfield, Ill. 62703

Project No.: 11-P-97972/5-04 (Medicaid)
Funding: $ 168,252
Grantee: Department of Public Aid
931 East Washington Street
Springfield, Ill. 62703

Status: Coverage of services in Illinois was initiated July 1, 1982. The State has 12 providers participating in the demonstration in both Medicare and Medicaid. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration-awareness program has been developed within the target area. Illinois has developed a prospective rate for alcoholism services that is being used in the project. The project is in its fourth year of funding. As of August 1985, a total of 200 Medicare beneficiaries and 680 Medicaid recipients entered treatment at the 12 sites. The project is scheduled to end on January 29, 1986.

Alcoholism Services under Medicare and Medicaid: Michigan Demonstration

Project No.: 95-P-97975/5-04 (Medicare)
Funding: $ 54,176
Award: Grant
Grantee: Office of Substance Abuse Services
Department of Public Health
3500 North Logan
Box 30035
Lansing, Mich. 48909

Project No.: 11-P-97976/5-04 (Medicaid)
Funding: $ 258,793
Award: Grant
Grantee: Medical Services Administration
Department of Social Services
300 South Capital Avenue
Lansing, Mich. 48909

Status: Coverage of services in Michigan was initiated July 1, 1982. The State has 24 providers participating in the demonstration in both Medicare and Medicaid. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration-awareness program has been developed within the target area. The project is in its fourth year of funding. As of May 1985, a total of 596 Medicare beneficiaries and 2,000 Medicaid recipients entered treatment at the 24 sites. The project is scheduled to end on November 29, 1985.

Alcoholism Services under Medicare and Medicaid: New Jersey Demonstration

Project No.: 99-P-97973/2-04
Funding: $ 386,806
Award: Grant
Grantee: Division of Medical Assistance and Health Services
325 East State Street
Trenton, N.J. 08625

Status: Coverage of services in New Jersey was initiated August 1982 for Medicare and in October 1982 for Medicaid. The State has 24 providers participating in the demonstration in both Medicare and Medicaid. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration-awareness program has been developed within the target area. The project is in its fourth year of funding. As of July 1985, a total of 893 Medicare beneficiaries and 1,620 Medicaid recipients entered treatment at the participating 24 sites. The project is scheduled to end on December 29, 1985.

Alcoholism Services under Medicare and Medicaid: New York Demonstration

Project No.: 99-P-97979/2-04
Funding: $ 383,739
Award: Grant
Grantee: Division of Medical Assistance
Department of Social Services
40 North Pearl Street
Albany, N.Y. 12243

Status: Coverage of services in New York was initiated July 1, 1982. The State has 15 providers participating in the demonstration in both Medicare and Medicaid. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration-awareness program has been developed within the target area. The project is in its fourth year of funding. As of May 1985, a total of 342 Medicare beneficiaries and 802 Medicaid recipients entered treatment at the 15 sites. The project is scheduled to end on November 29, 1985.

Alcoholism Services under Medicare: Oklahoma Demonstration

Project No.: 95-P-97983/6-04
Period: September 1981 - December 1985
Funding: $ 574,872
Award: Grant
Grantee: American Indian Institute
University of Oklahoma at Norman
555 Constitution Avenue
Norman, Okla. 73037

Status: Coverage of services in Oklahoma was initiated July 1, 1982. The State has 19 providers participating in the demonstration in Medicare only. Provider staff have been trained in billing and cost-reporting procedures. A beneficiary and referral centers demonstration-awareness program has been developed within the target area. The project is in its fourth year of funding. As of July 1985, a total of 425 Medicare beneficiaries entered treatment at the 19 sites. The project is scheduled to end on December 29, 1985.

Evaluation of the Alcoholism Services Demonstration

Project No.:	500-83-0023
Period:	April 1983 - December 1986
Funding:	$ 2,644,996
Award:	Contract
Contractor:	Lawrence Johnson and Associates, Inc. 4545 42nd Street, NW. Washington, D.C. 20016
Project Officer:	Paul Lichtenstein Division of Health Systems and Special Studies

Description: This is an evaluation of the effectiveness of the demonstration that expands Medicare and/or Medicaid coverage to freestanding alcoholism treatment centers. It will examine the impact of the demonstration on the use and cost of services. The project is supported by funds from the National Institute on Alcohol Abuse and Alcoholism, Public Health Service, and the Health Care Financing Administration.

Status: The research design was completed in March 1983. The contractor is currently implementing the research design. The final report is due December 1986. The contractor has provided a case study and an interim analytical report on cost and use of services under the demonstration.

BENEFICIARY AWARENESS AND PREVENTION

Beneficiary Awareness

Cost of Care Information to Consumers

Funding: The Rand/University of California, Los Angeles Health Financing Policy Research Center (See page 186)

Project Officer: John C. Langenbrunner Division of Reimbursement and Economic Studies

Description: Recent changes in Federal payment policy have contributed to a growing recognition of the importance of providing consumers with medical information on health care costs. A few programs providing such information have been in place for some time, and many more are being developed. The Federal Government is also concerned with increasing consumers' access to information that will enable them to make informed choices in the health care market. This study begins to develop the data necessary to assess the value of programs to provide consumers with information about health care costs and to examine models for such programs. Consumer education efforts may improve market efficiency by increasing the level of information that consumers bring to decisionmaking. However, there are costs associated with communicating information to consumers. To assess the cost/benefit tradeoff requires information about present knowledge that consumers have, the impact of knowledge on decisionmaking, and the cost effectiveness of alternative dissemination policies. The objective has been to gather existing evidence on these issues and to propose an agenda for future research. The research approach proceeded along two parallel lines. One approach analyzed the existing empirical and theoretical literature concerning consumer decisionmaking and information processing in the health sector. The second approach surveyed current efforts to distribute information to consumers, emphasizing programs aimed at Medicare beneficiaries.

Status: The Social Security Amendments of 1983 (Public Law 98-21) required that a report be submitted to the Congress on the "advisability of having hospitals make available information on the cost of care to patients financed by both public programs and private payers." The Health Care Financing Administrtation utilized the research findings of this study in developing the report. Released in August 1985, this Report to Congress offered some key considerations for those in both the public and non-governmental sectors who design information programs.

Consumer as a Partner in Medical Cost Containment

Project No.:	500-84-0063
Period:	May 1, 1985 - September 15, 1987
Funding:	$ 231,254
Award:	Contract
Contractor:	KENEKO Communications 1700 Mission Street, Suite 204 Santa Cruz, Calif. 95060
Project Officer:	David Schwartz Division of Research and Demonstrations Systems Support

Description: This project is authorized under the Small Business Innovation Development Act of 1982 (Public Law 97-219). The project is to develop a medical guide that will give information and assistance to consumers. Phase I consisted of obtaining commitments from test sites, the development of test measures, the development of testing programs, and examination of base-line data at the test sites. Phase II of the project will be a study using the instruments, test measures, and handbook developed during Phase I to evaluate the effectiveness of a Health Consumer Training Program (HCTP). The HCTP will be given to 1,800 employees of 5 corporations.

Status: The Phase I portion of the project was completed on April 30, 1985. It has been decided to continue funding under Phase II of the Small Business Innovation Research Program. Phase II will evaluate the effectiveness of a Health Consumer Training Program.

Child Health

Health Care Services for Children Under Medicaid

Project No.:	**18-P-98011/3**
Period:	**August 1981 - October 1985**
Funding:	**$ 504,311**
Award:	**Grant**
Grantee:	**Johns Hopkins University** **School of Medicine** **Department of Pediatrics** **720 Rutland Avenue** **Baltimore, Md. 21205**
Project Officer:	**Benson Dutton** **Division of Reimbursement and Economic Studies**

Description: This is a grant for a comparative study of health care services for children by using billing claims and eligibility data files from the State of Maryland. The grantee seeks information on the cost and effectiveness of services for children eligible for the Medicaid Early and Periodic Screening, Diagnosis, and Treatment Program. Data on the costs and utilization of services for children using private practitioners, hospital clinics, emergency rooms, and various combinations of delivery systems serve as the basis for this analysis.

Status: Using the data files for the Johns Hopkins Hospital Title V, Children and Youth Clinic, use of services by Medicaid and self-pay patients have been compared. Within an organized program, differences were small. The implications of these findings were explored, particularly in light of other studies. Services for children with asthma were studied in the Children and Youth Project and in the middle class population of the Columbia, Maryland Medical Plan. Services were far more numerous and thus, more costly for the children and youth Medicaid population than for Columbia. The monitoring of Medicaid services, including diagnosis-specific studies for other chronic and acute problems, with cost containment as the goal, will be tested against the large State Medicaid file. A final report is expected in early 1986.

Prenatal Care and Its Relationship to Medicaid Costs

Project No.: 11-P-98305/7-02
Period: March 1983 - December 1984
Funding: $ 78,679
Award: Grant
Grantee: Missouri Division of Health
Broadway State Office Building
P.O. Box 570
Jefferson City, Mo. 65102
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: This project linked birth certificate records with Medicaid obstetrical and newborn records. The combined data set was used to study the obstetrical and newborn Medicaid costs associated with women who receive preventive prenatal services as opposed to those who do not receive adequate services. The primary goal of the project was to determine if the Medicaid coverage provided for Medicaid mothers obtaining adequate prenatal care is cost beneficial.

Status: Findings from this study suggest that there is a net increase in Medicaid costs by providing adequate prenatal care. However, the costs of providing adequate prenatal care are small when compared with the overall Medicaid budget for mothers and newborns. The reduction in low-birth-weight rates and possible reduction in neonatal mortality among the babies of mothers with adequate prenatal care suggest that this is a worthwhile investment. The final report is available from the National Technical Information Service, accession number PB85-195352/AS.

Medicaid Child Health Care Evaluation

Project No.: 500-84-0037
Period: September 1985 - June 1986
Funding: $ 60,000
Award: Contract
Contractor: SysteMetrics, Inc.
24 Hartwell Avenue
Lexington, Mass. 02173
Project Officer: Gerald S. Adler
Division of Beneficiary Studies

Description: The study takes an intensive look at the characteristics, use, and cost of care for selected subgroups of the child Medicaid population, by using person-based data from five State management information systems (Tape-to-Tape). Groups include poor children in intact families (Ribicoff children), disabled children, those in institutions for the mentally retarded, and newborns. These are presented in the context of overall Medicaid utilization by children.

Status: The study was funded in September 1985 and is in an early stage.

AFDC/Medicaid Eligibility - Impact on Prenatal Care Use

Project No.:	IAA-85-0387
Period:	September 1984 - August 1986
Funding:	$ 74,553
Award:	Interagency Agreement
Grantee:	Human Services Development Institute University of Southern Maine 246 Deering Avenue Portland, Maine 04102
Project Officer:	Gerald S. Adler Division of Beneficiary Studies

Description: This project is funded jointly, through an interagency agreement, by the Health Care Financing Administration and the Public Health Service, Division of Maternal and Child Health. The project examines the factors that determine whether or not prenatal care will be used, focusing on Medicaid/Aid to Families with Dependent Children eligibility policy as a key variable. Selected States, some with broad and some with stringent eligibility policies for pregnant women, will be compared. Other variables include characteristics of the mother, the family, and the medical care system that foster or impede adequate prenatal care. Data are obtained from birth records and surveys.

Status: The study includes participation by five States. The study for one State has been completed, the survey is under way in another State, and the sample of mothers is being drawn in the rest.

Other Prevention

Municipal Health Services Program

Period:	**August 1979 - December 1985**
Award:	**Cooperative Agreement**
Participants:	**Baltimore, Md.**
	Cincinnati, Ohio
	San Jose, Calif.
	St. Louis, Mo.
	Milwaukee, Wis.
Project Officer:	**Kathleen Farrell**
	Division of Health Systems and Special Studies

Description: **Municipal Health Services Program (MHSP) is a collaborative effort of five major cities in five States, the U.S. Conference of Mayors, the Robert Wood Johnson Foundation (RWJF), and the Health Care Financing Administration (HCFA). It was initiated by RWJF through grants of $3 million awarded in June 1978 to each of the following five cities: Baltimore, Cincinnati, Milwaukee, St. Louis, and San Jose. HCFA joined in the project by providing Medicare waivers through a cooperative agreement and Medicaid waivers through grants to four of the five States to test the effects of increased utilization of municipal health centers by:**

- **Eliminating coinsurance and deductibles.**
- **Expanding the range of covered services.**
- **Paying the cities the full cost of delivering services at the clinics.**

The intent of the waivers is to shift fragmented utilization away from costly hospital emergency rooms and outpatient departments toward lower cost Municipal Health Services Program (MHSP) clinics which would provide beneficiaries with comprehensive primary and preventive health care.

Status: **The first city began billing under the Medicare waiver in August 1979. Four of the five cities (all except Cincinnati) desired to use Medicaid waivers as well, and this brought in participation of the State governments in 1981. As of June 1984, the five MHSP cities have a total of 19 clinics operating, bringing together both public and private health-related organizations. A wide variety of services are offered, including medical, social, mental, preventive, dental, pharmacy, optometry, podiatry, and rehabilitation. Clinic utilization ranges widely from 700 visits per year to 40,000 visits per year. Average provider productivity ranges from 3,200 to 4,500 annual visits per full-time equivalent provider. Waivers were scheduled to terminate December 31, 1984; however, in response to proposals from four of the cities (St. Louis chose not to request an extension) to go at full risk and capitate Medicare Parts A and B services in 1986, HCFA agreed to extend the Medicare waivers 1 additional year, through December 1985.**

Evaluation of Municipal Health Services Program

Project No.:	**500-78-0097**
Period:	**September 1978 - March 1985**
Funding:	**$ 3,105,250**
Award:	**Contract**
Contractor:	**University of Chicago** **5720 South Woodlawn Avenue** **Chicago, Ill. 60637**
Project Officer:	**Tony Hausner** **Office of Demonstrations and Evaluations**

Description: This is an evaluation of the Municipal Health Services Program (MHSP) demonstrations. It is a collaborative effort with the Robert Wood Johnson Foundation. The evaluation covers the quality and efficiency of services delivered in urban clinics in five cities (Baltimore, Cincinnati, Milwaukee, St. Louis, and San Jose).

Status: The University of Chicago submitted the final report in April 1985. This evaluation indicates that MHSP did reach most, but not all of the targeted groups. Although MHSP successfully replaced some outpatient departments and emergency room services, it failed to realize some of the program goals of continuity and high patient satisfaction. The evaluation found that the per capita costs of medical care for all MHSP users were not significantly different than the comparison group. However, the per capita costs for Medicare eligible MHSP users were significantly less than the comparison group.

Quality and Effectiveness of Preventive Medical Care

Project No.: 18-P-97777/9
Period: September 1980 - January 1985
Funding: $ 596,804
Award: Grant
Grantee: The Rand Corporation
1700 Main Street
Santa Monica, Calif. 90406
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: This study focuses on the effect of preventive care on various categories of medical expenditure and any losses attributed to sickness. Issues and questions to be addressed include:

- The effects of preventive care on health status, medical care use, and work time available.
- The responsiveness of consumer demand to changes in the price of preventive care.
- The amounts of preventive care used in prepaid systems versus fee-for-service practice settings, both with no out-of-pocket charges.
- Whether or not people choosing the prepayment plan are fundamentally different in their desires to obtain preventive care.

The study will use data from the Rand Health Insurance Study (HIS), a social experiment in which families are assigned to several different health insurance plans. Approximately 8,000 individuals have been enrolled at six sites across the country: Dayton, Ohio; Seattle, Wash.; Fitchburg, Mass.; Franklin County, Mass.; Charleston, S.C.; and Georgetown County, S.C.

Status: To date, this project has produced analyses of the frequency and cost of medical visits involving nonpreventive care and hospitalizations. Findings from this analysis indicate no significant effect of aggregate preventive activities on aggregate nonpreventive care, hospital visits, and costs. These findings were presented at the Conference on Productivity in Health, Stanford University, August 1983, and the Third International Conference on System Science in Health Care, Munich, Germany, July 1984. Rand has subsequently submitted a working draft entitled, "Preventive Medical Care: Standards, Usage, and Efficacy" examining the effects of use of health services and health status, frequency of preventive use, cost sharing, use of preventive services, and a discussion of the limitations of the study. A final report is expected Winter 1986.

Prevention of Future Utilization of Health and Long-Term Care Services

Project No.: 18-P-98288/3-03
Period: March 1983 - March 1986
Funding: $ 737,000
Award: Grant
Grantee: Johns Hopkins University
School of Hygiene and Public Health
615 North Wolfe Street
Baltimore, Md. 21205
Project Officer: James Hadley
Division of Health Systems and Special Studies

Description: Johns Hopkins is evaluating an intervention project conducted at New York University Hospital, entitled "Cooperative Care" in which chronically ill Medicare beneficiaries and their care partners are trained in self-care techniques. The purpose of the project is to reduce the high rate of post-discharge rehospitalizations for certain chronic conditions (e.g., heart disease) through good home-care monitoring. Cooperative Care, a 4-day inpatient education program, emphasizes the care partner's role in reinforcing patients to take their medication and to adhere to diet and exercise regimens.

Status: Since the beginning of the study, 456 patients plus 456 care partners have been randomly assigned to either the experimental or control group. Approximately 80 percent of the experimental patients are transferred into Cooperative Care from New York University Hospital, and the other 20 percent are directly admitted to the program. Approximately 456 patients (plus their care partners) in the study have completed the first followup questionnaire (2 weeks), and more than 280 pairs have completed the 6-month followup questionnaire. For the 9-month utilization followup, 164 patients have been contacted; for the 12-month utilization followup, 145 patients have been interviewed. The project will continue through March 1986.

Prevention of Falls in the Elderly

Project No.:	**95-C-98578/9-01**
Period:	**September 1984 - February 1988**
Funding:	**$ 375,000**
Award:	**Cooperative Agreement**
Awardee:	**Kaiser Foundation Research Institute Health Services Research Center 4810 Southeast Belmont Street Portland, Oreg. 97215**
Project Officer:	**Leslie N. Saber Division of Long-Term Care Experimentation**

Description: In September 1984, a cooperative agreement was awarded to the Kaiser Foundation Research Institute to test the effectiveness of a comprehensive program for the prevention of falls in the elderly. The project will be conducted at the Health Services Research Center, Kaiser Permanente Medical Care Program, in Portland, Oreg. Kaiser will conduct a randomized trial of 2,400 households with Kaiser members 65 years of age or over who will participate in two groups—an intervention group and a control group. All participants will provide data on falls and will receive a home audit. Participants in the intervention group will be offered a special falls prevention program which will include a self-management educational curriculum and the installation of safety equipment and minor renovations in the home. In addition, a blind control group of elderly Kaiser members will be included to measure the incidence of falls-related medical care use. The project will collect data for a 24-month period on all participants. Funding support for this demonstration will be supplemented by the National Institute on Aging, the Robert Wood Johnson Foundation, and Kaiser Foundation Hospitals, Inc.

Status: An interagency agreement with the National Institute on Aging to fund this project was finalized in March 1985. The project completed its planning and development activities and began recruiting participants in September 1985.

Trends in Pediatrician Participation in State Medicaid Programs

Project No.: 18-P-98265/5-01
Period: March 1983 - April 1985
Funding: $ 232,296
Award: Grant
Grantee: American Academy of Pediatrics
Department of Health Services Research
1801 Hinman Avenue
Evanston, Ill. 60204
Project Officer: Benson Dutton
Division of Reimbursement and Economic Studies

Description: The overall goal of this study was to measure and analyze trends in physician participation in Medicaid and the Early and Periodic Screening, Diagnosis, and Treatment program in the 13 States that were studied by the Health Care Financing Administration in 1979. The study also identified and recommended State-specific policy strategies for fostering the participation of primary care physicians in Medicaid, thereby promoting access of children to appropriate and efficient sites of preventive and acute care.

Status: A survey of physicians was undertaken during the first year of this project. Phone calls to nonrespondents were made to gather information for the response analysis. Descriptive statistical reports, for panel and sample, for each of the 13 study States, and replication of the 1979 multivariate analysis of determinants of pediatrician participation in Medicaid was completed. Project staff conducted analyses of competition and its effects on Medicaid participation. Preliminary findings from the project were presented at the 1984 American Public Health Association Annual Meeting. Findings from the study show that the vast majority of pediatricians continue to treat Medicaid patients. However, in 9 out of 13 States, one-third to one-half of these doctors now limit their Medicaid patient load in some way, for instance by taking only emergency cases, newborns, or referrals. Many physicians objected to low reimbursement rates, high collection costs, and the complexity of the Medicaid regulations. The most important findings may be the fact that Medicaid participation varies widely by State, suggesting that Medicaid policies can make a difference. The final report is available from the National Technical Information Service, accession number PB85-233426/AS.

The Economy and Efficacy of Medicare Reimbursement for Preventive Services

Project No.: 95-C-98516/4-01
Period: September 1985 - September 1991
Funding: $ 1,200,000
Award: Cooperative Agreement
Awardee: University of North Carolina
Department of Social and Administrative Medicine
300 Bynam Hall, 008A
Chapel Hill, N.C. 27514
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: The objective of this demonstration is to offer an expanded benefit package of preventive services to a selected group of Medicare beneficiaries and assess the impact of these services on subsequent utilization and costs of medical services and measures of health status. The awardee will conduct an evaluation of the prevention initiative. The package of preventive services is limited to $100 reimbursement per year and includes clinical services (e.g., hearing and vision exams, blood pressure screening, breast exam, pap smear, history and physical, hematocrit, influenza immunization, and stool for occult blood/digital rectal exam), and health education promotion services (e.g., medication awareness, smoking cessation, physical exercise, nutrition, mental hygiene, and risk reduction). The project will offer a package of screening services annually to beneficiaries 65 years of age or over, to be given by a medical doctor, and a health promotion package once every 2 years, to be given by a community health nurse. Physicians in hospital outpatient centers, neighborhood medical clinics, or private group practices will solicit volunteers from the pool of Medicare beneficiaries in their practices for this demonstration. Out of 3,600 eligibles, 1,500 (approximately 50 percent) are expected to participate. The experimental and control groups will be randomly assigned into two groups. Cost, utilization, and health status information will be collected from a variety of sources: provider record audits, hospital records, death certificates, HCFA's Medicare Automated Data Retrieval System (MADRS), and an annual health assessment survey.

Status: This project was awarded in September 1985, and implementation has just begun.

A Demonstration and Evaluation of a Preventive Services Package to Provide Early Detection of Illness and Monitoring of High-Risk Medicare Beneficiaries

Project No.: 95-C-98539/1-01
Period: September 1985 - September 1991
Funding: $ 1,200,000
Award: Cooperative Agreement
Awardee: Blue Cross of Massachusetts, Inc.
Health Program Development
100 Summer Street
Boston, Mass. 02106
Project Officer: John F. Meitl
Division of Health Systems and Special Studies

Description: The objective of this demonstration is to offer an expanded benefit package of preventive services to a selected group of Medicare beneficiaries and assess the impact of these services upon subsequent utilization and costs of medical services and measures of health status. The package of preventive services is limited to $100 reimbursement per year and includes clinical services (e.g., hearing and vision exams, blood pressure screening, breast exam, pap smear, history and physical, hematocrit, influenza immunization, and stool for occult blood/digital rectal exam), and health education promotion services (e.g., medication awareness, smoking cessation, physical exercise, nutrition, mental hygiene, and risk reduction). This project will offer an annual health education/promotion appraisal and clinical screening every 2 years, both delivered by a geriatric nurse practitioner to beneficiaries 65 years of age or over. Those beneficiaries identified as high risk by a functional assessment questionnaire will be seen on a quarterly basis and will receive medication monitoring. The eligible population of 10,000 Medicare beneficiaries living in ZIP codes that surround the Boston service delivery sites will be randomized into experimental and control groups, with 5,000 eligibles in each group. They will be invited to participate by the Health Care Financing Administration (HCFA), and 3,000 in the experimental group are expected to respond positively (60 percent). They will receive services at facilities that are not their usual sources of care. Of those 3,000, 20 percent (600) are projected to be at high risk and will be seen four times a year. Data will be collected from four sources:

- State vital statistics for death certificates.
- HCFA payment files.
- Blue Cross and Blue Shield claims file.
- A telephone survey to determine functional levels of a 30-percent random sample of experimental and control groups administered by the subcontractor, Brown University.

Status: The project was awarded in September 1985, and implementation has just begun.

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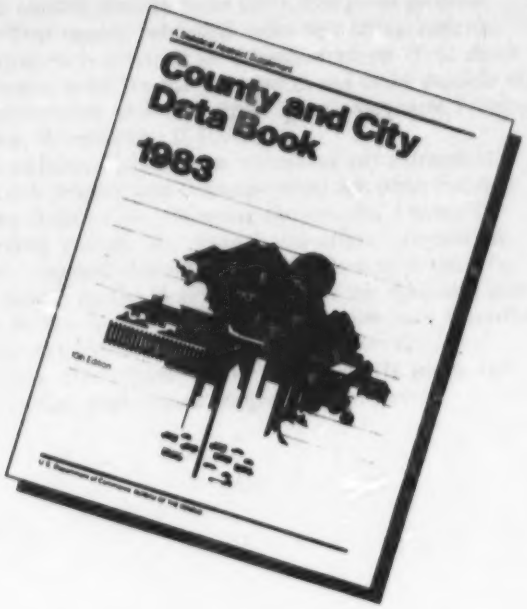
County and City Data Book ,1983

10th Edition



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